

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore 22 MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>as</i> b. COUNTY <i>as</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dundalk</i>		c. LENGTH OF STAY IN 1b <i>24 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8226 Bletzer Rd.</i>		d. STREET ADDRESS <i>#1.</i>	
3. NAME OF DECEASED (Type or print) <i>MARY T. ADAMS</i>		4. DATE OF DEATH <i>APRIL 20 1962</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MAR. 24. 1888</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	9. AGE (In years last birthday) <i>74</i> yrs.
11. BIRTHPLACE (State or foreign country) <i>Reading, Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Michael Susko</i>		14. MOTHER'S MAIDEN NAME <i>Mary Haddock</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Self.</i>		Address <i>as in #1.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adeno Carcinoma Ampulla Vater</i> <i>155.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Whipple operation</i> DUE TO (c) <i>on 2/15/62</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>Nov. 10 1961</i> to <i>April 20 1962</i> , that I last saw the deceased alive on <i>April 19 1962</i> , and that death occurred at <i>520</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Louis N. Tollin</i>		DATE SIGNED <i>4/20/62</i>	
PHYSICIAN'S NAME (Type) <i>LOUIS N. TOLLIN</i>		ADDRESS (Street, city or town, state) <i>6908 N. Gt Rd Balto 19-md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4-23-1962</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i>	22d. LOCATION (City, town, or county) (State) <i>Belair Road, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>JOHN J. DUDA 7922 Wise Ave. 22, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>APR 24 '62</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04166

04163

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2731 Arbutus Ave.		d. STREET ADDRESS 2731 Arbutus Ave.	
3. NAME OF DECEASED (Type or print) First STELLA Middle F. Last ADAMS		4. DATE OF DEATH Month April Day 28 Year 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1885
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Boyetown, Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jonathon D. Scheeler		14. MOTHER'S MAIDEN NAME Violet Fisher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Robert S. Adams, Jr.		Address 2731 Arbutus Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic CVD DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan., 1962 to April 28, 1962 , that I last saw the deceased alive on April 27, 1962 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert J. Levickas M.D.		ADDRESS (Street, city or town, state) 2436 Washington Blvd. Baltimore - 30 Md.	
DATE SIGNED 4/30/62			
PHYSICIAN'S NAME (Type) Herbert J. Levickas			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 5/1/62	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN F. DENNY, Inc.		ADDRESS 715 Light St.	
24a. REC'D BY REGISTRAR MAY 2 1962		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 7 be retained by the hospital or attending physician.
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
04164													
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>						c. LENGTH OF STAY IN 1b <u>X</u> <u>CATONSVILLE</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>613 BRAESIDE RD.</u>						d. STREET ADDRESS <u>613 BRAESIDE RD.</u>							
3. NAME OF DECEASED (Type or print) <u>BESSIE MARIE ANDERSON</u>						4. DATE OF DEATH Month <u>APR.</u> Day <u>22</u> Year <u>1962</u>							
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 14, 1899</u>		9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL TEACHER, PUBLIC SCHOOLS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. VA.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>SAMUEL V. THOMPSON</u>						14. MOTHER'S MAIDEN NAME <u>MARY A. WORMAN.</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>						16. SOCIAL SECURITY NO. <u>213-44-8094</u>							
						17. INFORMANT Address <u>MR. WILLIAM ANDERSON (SON)</u> <u>5302 EDMONDSON AVE.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-Vascular Renal Disease</u> DUE TO (b) <u>Chronic nephritis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>							
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> e.m. <u> </u> p.m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>						
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 18, 1956</u> to <u>April 22, 1962</u> that (I) (we) last saw the deceased alive on <u>April 21, 1962</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Harry L. Kniff</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u> </u>					
22c. PHYSICIAN'S NAME (Type) <u>HARRY L. KNIFF, M.D.</u>						22d. ADDRESS <u>4116 Edmondson Ave. Balto. 29, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>4/25/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE PARK</u>			23d. LOCATION (City, town or county) (State) <u>WOODLAWN MD.</u>					
24 FUNERAL DIRECTOR'S SIGNATURE <u>WITZKE, 4101 EDMONDSON AVE.</u>						ADDRESS <u> </u>		25a. REC'D BY REGISTRAR DATE <u>APR 26 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kniss</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04168

CERTIFICATE OF DEATH

04165

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4820 Eldon Green		d. STREET ADDRESS 4820 Eldon Green	
3. NAME OF DECEASED (Type or print) Ruth F. Bacon		4. DATE OF DEATH Month April , Day 18 , Year 1962	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1922
9. AGE (In years last birthday) 39		10. IF UNDER 1 YEAR Months 1 Days 19 Hours 62	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		11b. KIND OF BUSINESS OR INDUSTRY Rhode Island	
12. CITIZEN OF WHAT COUNTRY? U. S.A.		13. FATHER'S NAME Donald C. Stickell	
14. MOTHER'S MAIDEN NAME Edith G. Hess		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Franklyn C. Bacon, 4820 Eldon Green #27	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Carcinoma of Breasts 170X DUE TO Conditions, if any, which gave rise to immediate cause (b) 170X (c), stating the underlying cause last. DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
22a. TIME OF INJURY Month, Day, Year Hour 19 e.m. p.m.		22b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22d. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 1956 to April 18, 1962, that (I) (we) last saw the deceased alive on April 16, 1962, and that death occurred at 6 A.M. from the causes and on the date stated above.			
22a. SIGNATURE I. Earl Pass, M. D.		22b. DATE SIGNED 4-18-62	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 4001 Wilkens Avenue, Balto. 29, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/20/62	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Balto., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard, 4107 Wilkens Avenue #29		25a. REC'D BY REGISTRAR DATE APR 23 '62	
25b. REGISTRAR'S SIGNATURE William L. Thomas			

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London Park Cemetery, Baltimore, Md.

Also

London Park Cemetery, Baltimore, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04169

CERTIFICATE OF DEATH

04166

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X -- Towson -- Towson</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8201 Loch Raven Blvd</u>				d. STREET ADDRESS <u>8201 Loch Raven Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mr. John Poole Bamberger, Sr.</u>				4. DATE OF DEATH Month <u>April</u> Day <u>8th</u> Year <u>1962</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 11, 1892</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Butcher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph W. Bamberger</u>				14. MOTHER'S MAIDEN NAME <u>Virginia C. Poole</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>213-03-4185</u>				17. INFORMANT <u>Mrs. Nancy Bamberger</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO (b) <u>ARTERIOSECTERIC CARDIOVASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>420 -</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u> <u>5 YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 11, 1957</u> to <u>APRIL 5, 1962</u> ; that (I) (we) last saw the deceased alive on <u>Feb. 28, 1962</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Adam G. Swiss</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>APRIL 4, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>ADAM G. SWISS</u>				22d. ADDRESS <u>6232 BELAIR ROAD, BALTO. MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/11/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5395 Harford Road #04</u>		25a. REC'D BY REGISTRAR <u>APR 10 1962</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur L. Moore</u>	

VR A15 (4)
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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<div> <div>1</div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div> <div> <div>04170</div> <div>04167</div> </div> </div>											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 2yr13dys c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, If institutions: Residence before admission) a. STATE Maryland b. COUNTY ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3v01-4 d. STREET ADDRESS 259 S. East Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Garland Middle F. Last Barnes						4. DATE OF DEATH Month April Day 2 Year 19 62					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> sep. <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 5, 1904		9. AGE (In years last birthday) 57 yrs. IF UNDER 1 YEAR: Months 57 Days 57 Hours 57 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) grinder	
11b. KIND OF BUSINESS OR INDUSTRY Machine				11. BIRTHPLACE (County & State, or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Jacob Barnes						14. MOTHER'S MAIDEN NAME Mary Ann					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown				16. SOCIAL SECURITY NO. 229-18-7686		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of lung with cerebral, adrenal and other metastases. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (IX (this hospital) attended the deceased from March 19, 1960 to April 2, 1962, that (X) (we) last saw the deceased alive on April 2, 1962, and that death occurred at 7:45 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Stella Wachslar M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4-3-62		22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.	
22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF APRIL 6, 1962		23c. NAME OF CEMETERY OR CREMATORY Liberty Cem.		23d. LOCATION (City, town or county) (State) PARKSLEY VA.			
24. FUNERAL DIRECTOR'S SIGNATURE George J. Gorce						ADDRESS 4001 Ritchie Hwy		25a. REC'D BY REGISTRAR APR 4 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

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UNITED STATES OF AMERICA

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04168

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WOODLAWN		c. LENGTH OF STAY IN lb LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2016 OAK DRIVE		e. STREET ADDRESS 3201 STRICKLAND ST.	
3. NAME OF DECEASED (Type or print) ANNA B. BAXTER		4. DATE OF DEATH APR. 28, 1962	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUN. 6, 1892
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (County & State, or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LOUIS SCHLISING		14. MOTHER'S MAIDEN NAME CATHERINE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 216-245582	
17. INFORMANT MRS CATHERINE E. SKIPPER		Address 2016 OAK DRIVE, BALTO. 7, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lympho Lymphosarcoma c General 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Abdominal Metastasis (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/3 19 62 to 4/28 19 62 , that (I) (we) last saw the deceased alive on 4/24 19 62 , and that death occurred 258A from the causes and on the date stated above.			
22a. SIGNATURE Eliot W. Johnson		22b. DATE SIGNED 4/30/62	
22c. PHYSICIAN'S NAME (Type) ELIOT W. JOHNSON MD		22d. ADDRESS 3432 Madison Ave. Baltimore 29 Md	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 5/1/62	23c. NAME OF CEMETERY OR CREMATORY LOUPON PK. CEMT.	23d. LOCATION (City, town or county) (State) BALTO. MD.
24. FUNERAL DIRECTOR'S SIGNATURE WITKE, 4101 EDMONDSON AVE.		25a. REC'D BY REGISTRAR MAY 1 '62	
ADDRESS		25b. REGISTRAR'S SIGNATURE C. H. S. King	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 04169										
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Phenix Md.</u>			c. LENGTH OF STAY IN 1b <u>4 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Phenix, Md.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Stockton Rd.</u>					d. STREET ADDRESS <u>Stockton Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Delores</u> Last <u>Beale</u>					4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1962</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/5/1961</u>		9. AGE (In years last birthday) yrs. <u>4</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baby</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Md. (Baltimore City)</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Robert Beale</u>					14. MOTHER'S MAIDEN NAME <u>Edith Beale</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Name <u>Robert Beale</u> Address <u>Phenix, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation by aspiration of food</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>A. M. France</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>					DATE SIGNED <u>4/23/62</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/24/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>STVENSON CEMETERY</u>			22d. LOCATION (City, town, or county) (State) <u>Sparks Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm A. Jackson Fun Home Inc.</u>					ADDRESS <u>Balto, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 25 62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. France</u>	

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MONTANA STATE DEPARTMENT OF HEALTH - BILLINGS 10

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED'S NAME (Print Name) _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE (Years) _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		OCCUPATION _____	
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		PRESENT ADDRESS _____	
DECEASED'S SIGNATURE _____		MEDICAL EXAMINER'S SIGNATURE _____	
DATE OF DEATH _____		TIME OF DEATH _____	
PLACE OF DEATH _____		CAUSE OF DEATH (List in order) _____ _____ _____	
MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined		MEDICAL EXAMINER'S NAME _____	
MEDICAL EXAMINER'S ADDRESS _____		MEDICAL EXAMINER'S PHONE _____	

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RECEIVED - CHAIR

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04171

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN b. 1 Day		d. STREET ADDRESS 922 Leeds Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital			
3. NAME OF DECEASED (Type or print) COLUMBUS First GUSTAVUS Middle ADOLPHUS BIEN		4. DATE OF DEATH Month April Day 29 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9-27-92
9. AGE (In years last birthday) 69 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Bien		14. MOTHER'S MAIDEN NAME MARY THOMAS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-1 216-32-8185	
17. INFORMANT Clinical Records VAH Fort Howard Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PASSIVE CONGESTION LIVER, SPLEEN, KIDNEYS DUE TO (c) UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) TERMINAL BRONCHO PNEUMONIA BILATERAL			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 28 19 62 to April 29 19 62 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 29 19 62 , and that death occurred at 8:20 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Sebastian Russo M.D.		22b. DATE SIGNED 4-30-62	
22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M. D.		22d. ADDRESS VAH, Fort Howard, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/3/62	23c. NAME OF CEMETERY OR CREMATORY Balto. National Cem.	23d. LOCATION (City, town or county) (State) Baltimore, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek 3331 Bréhms Lane		25a. REC'D BY REGISTRAR DATE MAY 2 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Baltimore

Veterans Administration Hospital

925 Leads Avenue

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Plumber

Plumbing Company

Baltimore, Maryland

U.S.A.

John Ryan

MARY WYNN

Yes

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210-32-0162

Clinical Records VAN Fort Howard Maryland

ATLANTIC OCEANIC STEAMSHIP LINE

EXCESSIVE CONSUMPTION LIVER, STOMACH, KIDNEY

TECHNICAL BUREAU PHOTOGRAPHY

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April 29

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April 28

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April 29

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Signature

REINHOLD W. H.

VAN, Fort Howard, Maryland

4-30-22

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FOR STATE
HEALTH DEPT
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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04172

1. PLACE OF DEATH a. COUNTY Baltimore			2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Md b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5 Overbrook Ave			d. STREET ADDRESS 5 Overbrook Ave		
3. NAME OF DECEASED (Type or print) John William Borchers Sr.			4. DATE OF DEATH Month April Day 23 Year 1962		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Oct. 24, 1902		9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 3 Days 23	
10a. USUAL OCCUPATION (Give kind of work done during most of working life) Butcher		10b. KIND OF BUSINESS OR INDUSTRY Meats		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry H. Borchers		14. MOTHER'S MAIDEN NAME Not known	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT Margaret Borchers Address 5 Overbrook Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage DUE TO Cancer of the Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation Oct. 3-61 on Lung removal of growth					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Geo. S. M. Kieffer		M.D.		DATE SIGNED	
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county) #1616 Leeds Ave. 4-22-62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-25-1962		22c. NAME OF CEMETERY OR CREMATORY Western Cemetery	
22d. LOCATION (City, town, or county) Baltimore - Maryland		22e. (State)		22f. (County)	
23. FUNERAL DIRECTOR Mac Nuts for 301 Redwood Road - 28		ADDRESS		24a. REC'D BY REGISTRAR APR 26 '62	
24b. REGISTRAR'S SIGNATURE Arthur L. Thoms		DATE			

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Bellevue

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Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

John William Borchers Jr.

April

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Oct. 20, 1902

White

Male

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U.S.A.

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Operation Oct 2-61 on lung removal of growth

1010 Leach Ave. 4-22-61

Doc. E. A. Miller M.D.

4-27-1902
John William Borchers Jr.
Bellevue

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT. M

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TO HOSPITAL OR DURING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4,		c. LENGTH OF STAY IN 1b 11 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 43 Burke Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annabel Middle Stein Last Brandt		4. DATE OF DEATH Month 4 Day 14 Year 19 62	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-14-1885
9. AGE (In years last birthday) 76 yrs.		10. UNDER 1 YEAR Months 76 Days 76 Hours 76 Min.	11. UNDER 24 HRS. Months 76 Days 76 Hours 76 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ????? Stein		14. MOTHER'S MAIDEN NAME Elizabeth Herbig	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Clarence Brown		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 420-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420-1 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/20 19 59 to 4/14 19 62 that (I) last saw the deceased alive on 4/14 19 62 and that death occurred at 9:22 M. from the causes and on the date stated above.			
22a. SIGNATURE W. M. Smith		22b. DATE SIGNED 4/14/62	
22c. PHYSICIAN'S NAME (Type) W. M. Smith M.D.		22d. ADDRESS 6305 THE ALAMEDA BALTO	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-17-62	
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City, town, or county) (State) Summerton, Penn.	
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Inc., Towson 4, Md.		25a. REC'D BY REGISTRAR DATE APR 16 '62	
25b. REGISTRAR'S SIGNATURE Wm. S. Thayer			

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STATE OF TEXAS

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ARMACOST NURS. HOME.		d. STREET ADDRESS FORMERLY OF 4904 ALSON DR.	
3. NAME OF DECEASED (Type or print) MARGARET E. BRENNAN		4. DATE OF DEATH APR. 29, 1962	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH JULY 12, 1875	9. AGE (In years last birthday) 86 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (County & State, or foreign country) MD.
13. FATHER'S NAME THOMAS BRENNAN		14. MOTHER'S MAIDEN NAME MARGARET MITCHELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		17. INFORMANT MISS MARGARET E. BRENNAN, 320 E. BELVEDERE AVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Generalized Arteriosclerosis (c) Cardio-Renal Vase Disease		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 yrs.			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/29, 1962 to 4/29, 1962 , that (I) (we) last saw the deceased alive on 4/29, 1962 , and that death occurred at 7:15 AM , from the causes and on the date stated above.			
22a. SIGNATURE Charles F. O'Donnell		22b. DATE SIGNED 4/30/62	
22c. PHYSICIAN'S NAME (Type) Charles F. O'Donnell MD 7101 York Rd #4 MD		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5/1/62	23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL	23d. LOCATION (City, town or county) (State) BALTO. MD.
24 FUNERAL DIRECTOR'S SIGNATURE WITKE, 4101 EDMONDSON AVE.		25e. REC'D BY REGISTRAR DATE MAY 2 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

CONTINUATION OF INQUIRY

1170

(M)

BALTIMORE

FOR 2007

CHITON

REINVESTMENT FUND

INVESTMENT FUND

INVESTMENT FUND

100.00

M.D.

TIME

MILE

THOMAS BRENNAN

MARGARET MITCHELL

AND MARGARET F. BRENNAN
210 E. BALTIMORE ST.

(1)

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u> c. LENGTH OF STAY IN 1b <u>6 yrs</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u> d. STREET ADDRESS <u>1 Mt. Zion Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Grace E. Brent</u>		4. DATE OF DEATH <u>April 21, 1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 11, 1886</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Cockeysville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles W. McCann</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Ayres</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>_____</u>	
17. INFORMANT <u>_____</u>		Address <u>_____</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>_____</u> (a), stating the underlying cause last, DUE TO (c) <u>_____</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>_____</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>_____</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>_____</u>	20f. (City or town) (County) (State) <u>_____</u>
21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> to <u>4/21</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>4/21</u> , 19 <u>62</u> , and that death occurred at <u>9:21 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>A. M. France</u>		22b. DATE SIGNED <u>4/21/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>		22d. ADDRESS <u>PARKTON, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 24, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Freeland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac H. Hertenstein</u>		24b. ADDRESS <u>New Freedom, Pa.</u>	
25a. REC'D BY REGISTRAR <u>APR 24 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. France</u>	

04178

04178

(M)

Frederick County, Maryland
April 7, 1914
George F. Johnson

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in the funeral director's office. After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04180

CERTIFICATE OF DEATH

Item 23b Film G311 4/19/62 mh

04177

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN lb 6 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY - c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 13 d. STREET ADDRESS 1202 North Curley Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) CIARENCE J. BROWN			4. DATE OF DEATH Month Day Year April 3 19 62		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1930	9. AGE (In years last birthday) 31 yrs.	10. IF UNDER 1 YEAR Months Days 3 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Porter - Hospital		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Clarence C. Brown			14. MOTHER'S MAIDEN NAME Ruth Brown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW Korean		16. SOCIAL SECURITY NO. 220-20-3500		17. INFORMANT Clinical Records VA HOSPITAL, FORT HOWARD, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RIGHT LOWER LOBE PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 470X					INTERVAL BETWEEN ONSET AND DEATH 3 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) March 28 1962	
20f. (City or town) Baltimore		20g. (County) Baltimore		20h. (State) Maryland	
21. I certify that 10 (this hospital) attended the deceased from March 28 1962 to April 3, 1962 that 11:25 A.M. (we) last saw the deceased alive on April 3 1962 , and that death occurred at A.M. from the causes and on the date stated above.					
22a. SIGNATURE SEBASTIAN RUSSO, M.D.		22b. DATE 4/3/62		22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 6-62		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	
23d. LOCATION (City, town or county) Baltimore 28, Maryland		23e. (State) Maryland		23f. (County) Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson		24a. ADDRESS 1000 Brantley Ave. Baltimore 17, Md.		25a. REC'D BY REGISTRAR APR 13 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas		25c. (City or town) Baltimore			

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04175

RECEIVED
U.S. DEPARTMENT OF JUSTICE
WASHINGTON, D.C.
APR 11 1930
BUREAU OF INVESTIGATION
DIVISION OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE
WASHINGTON, D.C.

REPORT
OF
SPECIAL AGENT
IN CHARGE
JAMES E. HANCOCK
TO
DIRECTOR
BUREAU OF INVESTIGATION
DIVISION OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE
WASHINGTON, D.C.
APR 11 1930
RE: [illegible]

[illegible text]

APR 11 1930
JAMES E. HANCOCK
SPECIAL AGENT
IN CHARGE
BUREAU OF INVESTIGATION
DIVISION OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital, or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04178

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>226 Main st</u>		d. STREET ADDRESS <u>226 Main street</u>	
3. NAME OF DECEASED (Type or print) <u>Grace M. Brown</u>		4. DATE OF DEATH <u>April 20 - 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-14-1882</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Samuel Bailey</u>		14. MOTHER'S MAIDEN NAME <u>Robinson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Daughter</u> Address <u>Edna Kenny - 226 Main st. Reisterstown</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>Left lobe pneumonia</u> DUE TO (c) <u>Congestive heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>5 days</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>A Leukemic Leukemia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>58</u> , to <u>April 20</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>April 17</u> , 19 <u>62</u> , and that death occurred at <u>225</u> M, from the causes, and on the date stated above.			
ACTUAL SIGNATURE <u>Martin J Feldman</u> M.D.		ADDRESS (Street, city or town, state) <u>#1 Cherry Hill Rd Reisterstown Md 4/2/62</u>	
PHYSICIAN'S NAME (Type) <u>Martin J Feldman M.D.</u>		DATE SIGNED <u>4/2/62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-23-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Grave Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville 8.Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank A Newell</u>		ADDRESS <u>Pikesville Md</u>	
24a. RECEIVED BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Catharine E. K...</u>	
DATE			

[Faint, illegible text from the reverse side of the page]

TO HOSPITAL death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04182											
04179											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 28yr7mth2dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodstock, Maryland				d. STREET ADDRESS none	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL											
3. NAME OF DECEASED (Type or print) Reginald Lee Brown						4. DATE OF DEATH Month April Day 15 Year 19 62					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 14, 1909		9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William H. Brown						14. MOTHER'S MAIDEN NAME Sadie Lee Cook Snyder					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right-sided heart failure 502.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary asthma DUE TO (c) Diffuse purulent bronchitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 13, 1962 , to April 15, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 15, 1962 , and that death occurred at 5:30 A.M. , from the causes and on the date stated above.											
22a. SIGNATURE Stella Wachsler M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4-16-62			
22c. PHYSICIAN'S NAME (Type) Stella Wachsler M. D.						22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-18-62		23c. NAME OF CEMETERY OR CREMATORY Mt. View				23d. LOCATION (City, town or county) (State) Alpha, Md			
24. FUNERAL DIRECTOR'S SIGNATURE FC Byrnes						25a. REC'D BY REGISTRAR DATE APR 17 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Hines			

VR A15 (4)
15M 9/60

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TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled out, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit.

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MEDICAL CERTIFICATION

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<div> <div> <div>1</div> <div>04183</div> </div> <div> <div>04180</div> </div> </div> <div> <div> <div>1</div> <div>0</div> </div> <div> <div>1</div> <div>0</div> </div> </div>											
<div> <div>1. PLACE OF DEATH</div> <div>a. COUNTY Baltimore</div> <div>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pikesville</div> <div>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 104 Sherwood Ave.</div> </div>						<div> <div>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</div> <div>a. STATE Maryland b. COUNTY Baltimore</div> <div>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pikesville</div> <div>d. STREET ADDRESS 104 Sherwood Ave.</div> <div>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> </div>					
<div> <div>3. NAME OF DECEASED (Type or print)</div> <div>First Florence Middle Hannah Last Buckman</div> </div>						<div> <div>4. DATE OF DEATH</div> <div>Month April Day 15 Year 1962</div> </div>					
<div>5. SEX Female</div>		<div>6. COLOR OR RACE White</div>		<div>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div>		<div>8. DATE OF BIRTH 6-16-1884</div>		<div>9. AGE (In years last birthday) 77 yrs.</div>		<div>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</div>	
						<div>11. BIRTHPLACE (County & State, or foreign country) Philadelphia</div>		<div>12. CITIZEN OF WHAT COUNTRY? U.S.A.</div>			
<div>13. FATHER'S NAME Benjamin Rhodes</div>				<div>14. MOTHER'S MAIDEN NAME Florence H. Gardner</div>							
<div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No</div>				<div>16. SOCIAL SECURITY NO. No</div>				<div>17. INFORMANT Address Mrs. Grover Cook, 3712 Lochearn Dr.</div>			
<div> <div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) Myocardial Infarction</div> <div>DUPLICATE (b) Coronary Artery Disease</div> <div>DUPLICATE (c) Coronary Artery Disease</div> </div> <div> <div>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> <div>420</div> </div> </div>											
<div> <div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div> <div>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> </div>											
<div> <div>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</div> <div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Explosion during sleep</div> </div>											
<div>20c. TIME OF INJURY Month, Day, Year</div> <div>Hour a.m. p.m. 19</div>			<div>20d. INJURY OCCURRED</div> <div>While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></div>			<div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div>			<div>20f. (City or town) (County) (State)</div>		
<div> <div>21. I certify that (I) (this hospital) attended the deceased from March 30, 1962 to April 15, 1962 that (I) (we) last saw the deceased alive on March 30, 1962, and that death occurred at 5:20 AM, from the causes and on the date stated above.</div> </div>											
<div>22a. SIGNATURE Sheldon Keylow</div>						<div> <div>22b. DATE SIGNED</div> <div>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></div> </div>					
<div>22c. PHYSICIAN'S NAME (Type)</div>						<div>22d. ADDRESS</div>					
<div>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial</div>			<div>23b. DATE THEREOF 4-18-1962</div>			<div>23c. NAME OF CEMETERY OR CREMATORY St. Thomas</div>			<div>23d. LOCATION (City, town or county) (State) Garrison Forest</div>		
<div>24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell</div>						<div> <div>25a. REC'D BY REGISTRAR APR 18 1962</div> <div>25b. REGISTRAR'S SIGNATURE Arthur S. Kline</div> </div>					

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TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural-Towson c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 10 Gunpowder Rd. 34		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Towson d. STREET ADDRESS 10 Gunpowder Rd. 34 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FREDERICK D. BURHOP		4. DATE OF DEATH April 24, 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 10, 1877
9. AGE (In years last birthday) 85		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired exporter	11. BIRTHPLACE (County & State, or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? usa		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Frances Pottberg-Glen Arm Rd. 34, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure (b) Aortic Stenosis (c) Coronary Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 9 months 5 years + 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from August 1957 to April 23, 1962 that (I) (we) last saw the deceased alive on April 23, 1962 and that death occurred 6:15A from the causes and on the date stated above.			
22a. SIGNATURE Charles E. Shaw M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED Apr 24, 1962
22c. PHYSICIAN'S NAME (Type) CHARLES E. SHAW, M.D.		22d. ADDRESS 5801 Loch Raven Blvd., Balto. 12, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/26/62	23c. NAME OF CEMETERY OR CREMATORY Prospect Hill	23d. LOCATION (City, town or county) (State) Flemington, New Jersey
24. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc. York Rd, Towson, Md.		25a. REC'D BY REGISTRAR DATE APR 26 '62	25b. REGISTRAR'S SIGNATURE Arthur L. Hays

MEDICAL CERTIFICATION

COOK-LOWSON, INC., NEW YORK, N.Y.

CONFIDENTIAL

Wilmington, New Jersey

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04185

CERTIFICATE OF DEATH

04182

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2980 Cornwall Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN THOMAS BUSCH				4. DATE OF DEATH April 11, 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 10, 1872	
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Busch				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No.				16. SOCIAL SECURITY NO. Mrs. James L. Stephenson 2980 Cornwall Road			
17. INFORMANT Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchiogenic Carcinoma of the Lung with generalized metastasis DUE TO (b) 162.01 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 5, 1962 to April 11, 1962 that (I) (we) last saw the deceased alive on April 11, 1962 and that death occurred at 4:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Eugene F. New EUGENE F. NEW				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/13/62	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS 7001 MORNINGTON ROAD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 14, 1962		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md.				25a. REC'D BY REGISTRAR APR 18 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

04182

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CERTIFICATE OF DEATH

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TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

04186

04183

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD, MARYLAND		c. LENGTH OF STAY IN lb 50 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 1947 W. MULBERRY STREET			
3. NAME OF DECEASED (Type or print) First THOMAS Middle H. Last BYRD				4. DATE OF DEATH Month APRIL Day 26 Year 1962			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1894		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months - Days -	IF UNDER 24 HRS. Hours - Min. -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler Cleaner		10b. KIND OF BUSINESS OR INDUSTRY Smelting & Refining Co		11. BIRTHPLACE (County & State, or foreign country) Surrey Co. Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Doctor Byrd				14. MOTHER'S MAIDEN NAME Mary J. Morgan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 212 10 1454		17. INFORMANT Clinical Records, V. A. Hospital Fort Howard, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4200 (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) UNKNOWN						INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) ADENOMA, THYROID, BENIGN PROSTATIC HYPERTROPHY, PULMONARY EMPHYSEMA. INCISIONAL WOUND RECENT, LEFT KNEE						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 7, 1962 to April 26, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 26, 1962 , and that death occurred at 8:30A.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Thomas F. Crahan</i> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4/26/62	
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M. D.				22d. ADDRESS VAH, FT. HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-31-62		23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat.		23d. LOCATION (City, town or county) (State) Baltimore md	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Chay O. Wilson</i>				ADDRESS <i>1000 Southy Ave</i>		25a. REC'D BY REGISTRAR DATE MAY 1 '62	
						25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kane</i>	

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OFFICE OF THE
JOINT CHIEFS OF STAFF
WASHINGTON, D.C.
MEMORANDUM FOR THE RECORD
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04187

04184

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Cockeysville</i> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Greentop Road</i>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>✓</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BALTIMORE</i> <i>3 VOI-4</i> d. STREET ADDRESS <i>1618 Northbourne Rd</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Mary Elizabeth Carr</i> First Middle Last			4. DATE OF DEATH <i>April 21st.</i> 19 <i>62</i> Month Day Year		
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>19 FEB 08</i>	9. AGE (In years last birthday) <i>54</i> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (County & State, or foreign country) <i>MASSACHUSETTS</i> 12. CITIZEN OF WHAT COUNTRY? <i>USA BIRTH</i>	
13. FATHER'S NAME <i>JOSEPH MENDO</i>			14. MOTHER'S MAIDEN NAME <i>ELIZABETH</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> 16. SOCIAL SECURITY NO. <i>178127850</i>		17. INFORMANT <i>HUSBAND</i> Address <i>SAME</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>HEPATIC FAILURE</i> DUE TO (b) <i>GENERALIZED CARCINOMATOSIS</i> DUE TO (c) <i>(R) ADENOCARCINOMA - BREAST</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <i>5 MOS</i> <i>1 YR</i> <i>3 YR</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <i>4/19/62</i> to <i>4/19/62</i>, that (1) (we) last saw the deceased alive on <i>4/19/62</i>, and that death occurred <i>4/21/62</i> from the causes and on the date stated above.					
22a. SIGNATURE <i>Donald O. Wood</i> 22b. DATE SIGNED <i>4/21/62</i>			22c. PHYSICIAN'S NAME (Type) <i>DONALD O. WOOD</i> 22d. ADDRESS <i>YORK RD & GREENWATER PK MD</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>4/24/62</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Dulaney Valley Mem.</i>		23d. LOCATION (City, town or county) (State) <i>BALTIMORE Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck Inc</i>			25a. REC'D BY REGISTRAR <i>APR 30 '62</i> 25b. REGISTRAR'S SIGNATURE <i>Wm L. Thrall</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4
may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

04188

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04185

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grays		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION River Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle C. Last CAVEY		4. DATE OF DEATH Month April Day 24 Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-16-1879
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Gas and Electric	
11. BIRTHPLACE (State or foreign country) Ellicott City, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles A. Cavey		14. MOTHER'S MAIDEN NAME Mary A. King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-5689	
17. INFORMANT Paul M. Cavey, River Road, Grays Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral artery arteriosclerosis DUE TO 334X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis, general; with associated myocardial insufficiency and arrhythmic fibrillation DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1961 , to April 24 1962 , that I last saw the deceased alive on April 23 1962 , and that death occurred at 4:54 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Ellicott City Md April 24-62			
ACTUAL SIGNATURE Robert B. Taylor		M.D. Ellicott City Md	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-27-62	
22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR DATE APR 26 '62	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 11 & 14, phone call Wilson F.H.

6/8/62

04186

1. PLACE OF DEATH a. COUNTY BALTO.		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) REISTERSTOWN		c. LENGTH OF STAY IN 1b 1 month		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 939 W. Broadway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alfred		First		Middle		Last Chappman		4. DATE OF DEATH Month April		Day 9		Year 1962			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 22, 1885		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Junk Collector				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Danville, Va.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME MASTAN				Chappman				14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give year or dates of service) 212-01-8953				17. INFORMANT				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (b) ARTERIOSCLEROTIC C.V. DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)												INTERVAL BETWEEN ONSET AND DEATH 1 HR. YEARS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (H) (this hospital) attended the deceased from 3/17 19 62 to 4/9 19 62 , that (H) (we) last saw the deceased alive on 4/9 19 62 , and that death occurred at 11:50 PM from the causes and on the date stated above.															
22a. SIGNATURE Martin E. Strobel				M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 4/9/62			
22c. PHYSICIAN'S NAME (Type) MARTIN E. STROBEL								22d. ADDRESS REISTERSTOWN MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4/14/62				23c. NAME OF CEMETERY OR CREMATORY MT. CALVARY CEM.				23d. LOCATION (City, town or county) (State) Brooklyn, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE E.O. Wilson				ADDRESS 1000 Bunting Ave.				25a. REC'D BY REGISTRAR DATE APR 26 '62				25b. REGISTRAR'S SIGNATURE Arthur S. Harris			

MEDICAL CERTIFICATION

1113

01186



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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04187

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ESSEY</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>329 Back River Neck Road</u>		d. STREET ADDRESS <u>1329 Back River Neck Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Subie (Susan) Cheatham</u>		4. DATE OF DEATH Month Day Year <u>April 6 1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Chad</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 17, 1898</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Na.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Na.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Na.</u>	
13. FATHER'S NAME <u>Richard Andrews</u>		14. MOTHER'S MAIDEN NAME <u>Susan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>James Cheatham 329 Back River Neck Rd.</u>	
17. INFORMANT <u>James Cheatham</u>		Address <u>329 Back River Neck Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertension</u> (c) <u>Arterio-Sclerosis</u> DUE TO (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>20 minutes</u> <u>10 years</u> <u>8 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 10, 1961</u> , to <u>April 6, 1962</u> , that (I) (we) last saw the deceased alive on <u>Apr. 5, 1962</u> , and that death occurred at <u>6:22 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Morris A. Jacobs</u> M.D.		22b. DATE SIGNED <u>4/7/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Morris A. Jacobs M.D.</u>		22d. ADDRESS <u>1010 NORTH Point Rd. Balt 24 Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal April 8/62</u>	23b. DATE THEREOF <u>April 8/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>McHerrin Na.</u>	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE <u>Milton E. Elicker 1129 N. Carroll St.</u>		25a. REC'D BY REGISTRAR <u>DATE APR 11 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Wm. S. Thomas</u>			

04197

CENTRAL OF DEN

2-28

209 South Main Street
St. Louis (Mo.)
March 1898

James C. Johnson
Care of
St. Louis
Mo.

James C. Johnson
Care of
St. Louis
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04191

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04188

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lutherville</i>	c. LENGTH OF STAY IN 1b <i>30 years</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lutherville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1425 Bellona Ave</i>		d. STREET ADDRESS <i>1425 Bellona Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Irene Gertrude Burton Cockey</i>		4. DATE OF DEATH <i>April 6 1962</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4 July 1888</i>
9. AGE (In years last birthday) <i>73</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Edwardsville, Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Burton</i>		14. MOTHER'S MAIDEN NAME <i>Nancy Bee</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Sond - Wilson</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> <i>331</i> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral and Generalized Arteriosclerosis</i> DUE TO (c) <i>19 years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes mellitus</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>December 1961</i> to <i>April 1962</i> , that (I) (we) last saw the deceased alive on <i>3 April 1962</i> , and that death occurred at <i>9:18 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Walter T. Kees</i>		22b. DATE SIGNED <i>6 April 1962</i>	
22c. PHYSICIAN'S NAME (Type) <i>WALTER T. KEES</i>		22d. ADDRESS <i>Cockeysville, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4/10/62</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Arbutus mem PK.</i>		23d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. L. Chatman Jr.</i>		25a. REC'D BY REGISTRAR <i>APR 10 '62</i>	
ADDRESS <i>1711 McCall St. Balto. Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hane</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04192					04189				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY BALTIMORE MARYLAND					a. STATE MARYLAND b. COUNTY -				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 17				
c. LENGTH OF STAY IN lb 2 Days					d. STREET ADDRESS 2000 BOLTON ST.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) HENRY J. COLE					4. DATE OF DEATH APRIL 27 19 62				
5. SEX MALE 6. COLOR OR RACE NEGRO					7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH September 1, 1893				
9. AGE (In years last birthday) 68 yrs.					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor				
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME John Cole					14. MOTHER'S MAIDEN NAME Elizabeth				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I					16. SOCIAL SECURITY NO. 219-01-1141				
17. INFORMANT CLINICAL RECORDS VAH, Fort Howard, Maryland					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA					24 Hours				
DUE TO 151X (b) CARCINOMA OF STOMACH					18 Months				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that D (this hospital) attended the deceased from 25 April, 1962 , to 27 April, 1962 that X (we) last saw the deceased alive on 27 April, 1962 , and that death occurred at 11:30 PM , from the causes and on the date stated above.									
22a. SIGNATURE Arthur A. Smith					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 1-3-62				
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery					23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland				
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson					25a. REC'D BY REGISTRAR DATE MAY 1 '62				
1000 ADDRESS Bronx Ave					25b. REGISTRAR'S SIGNATURE Arthur S. Thomas				

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Very faint, mostly illegible text covering the main body of the page, possibly a form or document with multiple sections.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LUTHERVILLE</u> c. LENGTH OF STAY IN 1b <u>6 HRS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>113 SHETLAND HILLS DRIVE</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MASS.</u> b. COUNTY <u>ATHOL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ATHOL</u> d. STREET ADDRESS <u>32 OLIVER ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>CATHERINE</u> Last <u>COLTON</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>9</u> Year <u>1962</u>													
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-18-92</u>		9. AGE (In years last birthday) <u>69</u> yrs. <table border="1"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>ROBERT GLASHEEN</u>				14. MOTHER'S MAIDEN NAME <u>Josephine DOOLAN</u>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>MRS. MARY MACIACIUS, DAUGHTER, 113 SHETLAND HILLS DR</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR ACCIDENT</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>1 MIN.</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>William A. Pillsbury</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED											
EXAMINER'S NAME (Type) <u>WILLIAM A. PILLSBURY</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Informant, Athol, Mass.</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal/Burial</u>		22b. DATE THEREOF <u>April 9, 1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Murphy Funeral Home</u>		22d. LOCATION (City, town, or country) (State) <u>Athol, Mass.</u>											
23. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>APR 11 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>											

MEDICAL CERTIFICATION

04130

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Our home

on

on 14th April, 1962, supply (more) home

London, England

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FOR STATE
HEALTH DEPT. **M**
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
04194 Item 1 Film G312 5/1/62 iwk 04191											
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				b. COUNTY [REDACTED]			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rosedale				c. LENGTH OF STAY IN 1b [REDACTED]				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore #24, 3v81-4			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) American Oil Station				d. STREET ADDRESS 1309 DeMarcy Way (O'Donnell Hgts.)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FREDERICK Middle AMBROSE Last CONRAD				4. DATE OF DEATH Month April Day 16 Year 19 62							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 15, 1921.		9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months 4 Days 16 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant				10b. KIND OF BUSINESS OR INDUSTRY Gas Station.				11. BIRTHPLACE (State or foreign country) Cresson, Pa.			
12. CITIZEN OF WHAT COUNTRY U.S.A.				13. FATHER'S NAME Walter A. Conrad				14. MOTHER'S MAIDEN NAME Gertrude T. Switzler.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. W.W. II 184-16-5344				17. INFORMANT Gertrude T. Conrad Address Same.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shotgun wound of brain 981X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Shot by unknown assailant during holdup							
20c. TIME OF INJURY Month, Day, Year Hour xxx 4/16/ 19 62				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Amer. Oil Station		20f. (City or town) Baltimore, Maryland		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/16/62 Address (Street, city, town, or county) _____											
ACTUAL SIGNATURE Russell S. Fisher M.D.				EXAMINER'S NAME (Type) Russell S. Fisher, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4-18-62.		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or country) 5501 Frederick Av. Balto. Md.		(State)	
23. FUNERAL DIRECTOR Charles S. Zeiler				ADDRESS 6224 Eastern Ave. Balto., Md.		24a. REC'D BY REGISTRAR APR 19 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE	

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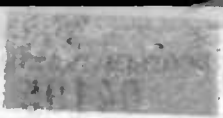
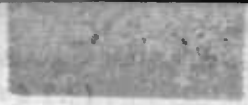
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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04195 CERTIFICATE OF DEATH 04192

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 55 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY 3v01-4 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1633 McCulloh Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN I COOK		4. DATE OF DEATH Month Day Year April 16 19 62	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-2-11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Messenger		10b. KIND OF BUSINESS OR INDUSTRY Social Security	9. AGE (In years last birthday) 50 IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
11. BIRTHPLACE (County & State, or foreign country) Allegheny County Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Cook		14. MOTHER'S MAIDEN NAME Blanche Hill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW-11		16. SOCIAL SECURITY NO. 217-09-7321	
17. INFORMANT Clin Rec VAH Fort Howard Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Metastatic Squamous Cell Carcinoma, Right Lung		INTERVAL BETWEEN ONSET AND DEATH 5 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb 20 1962 , to April 16 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 16 1962 , and that death occurred at 5:30 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Irving Freeman M.D.		22b. DATE SIGNED 4/17/62	
22c. PHYSICIAN'S NAME (Type) IRVING FREEMAN, MD, Chief, Medical Service VAH Ft Howard, Md		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/20/62	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City, town or county) (State) Baltimore Maryland
24. FUNERAL DIRECTOR'S SIGNATURE William I. Chatman Jr.		25a. REC'D BY REGISTRAR APR 18 '62	
ADDRESS 1701 McCulloh St Balto Md		25b. REGISTRAR'S SIGNATURE William I. Chatman Jr.	



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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

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04196
MAY 1962
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04193

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 54 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 232 Beaumont Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Nellie E. Cooke		4. DATE OF DEATH Month Day Year April 30, 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1879
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Self employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John R. Mc Comas		14. MOTHER'S MAIDEN NAME Mary Elizabeth Gosnell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-07-3592	
17. INFORMANT Mrs. Bertha M. Frazer		Address 1114 E. 30th. St. Balto.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 443X DUE TO HYPERTENSIVE CV DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) HYPERTENSIVE CV DISEASE (c) HYPERTENSIVE CV DISEASE		INTERVAL BETWEEN ONSET AND DEATH 18 HOURS 2 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JAN 4, 1961 to APR 30, 1962 , that (I) (we) last saw the deceased alive on APR 29, 1962 , and that death occurred at 3 P.M. from the causes and on the date stated above.			
22a. SIGNATURE John F. Schaefer		22b. DATE SIGNED MAY 2, 1962	
22c. PHYSICIAN'S NAME (Type) John F. Schaefer M. D.		22d. ADDRESS 401 Random Rd. Baltimore - Balto., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/3/1962	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Easton Funeral Home		25a. REC'D BY REGISTRAR DATE MAY 4 '62	
ADDRESS Catonsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. House	

Catonville, Md.

Baltimore, Md.

John F. Schaefer M. D.
401 Randan Md. Baltimore - Baltco., Md.

Burial

5/2/98

London Park

John F. Schaefer M. D.

No

216-07-3592

Mrs. Bertha H. Frazier 1114 E. 30th St. Baltco.

John R. McComas

Mary Elizabeth McDonald

Seamstress

Self employed

Maryland

U. S. A.

Female

White

X

July 14, 1879

82

Wells E. Cooke

232 Bennett Avenue
232 Bennett Avenue

Catonville

34 yrs.

Catonville

X

April 30, 02

Baltimore

Maryland

Baltimore

01133

CERTIFICATE OF DEATH

01198

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04197

CERTIFICATE OF DEATH

Reg. Dist. No. 04194

1. PLACE OF DEATH a. COUNTY <i>Baltimore - 19 -</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD. AS</i> b. COUNTY <i>BALTO.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparrows Pt</i>		c. LENGTH OF STAY IN 1b <i>2 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2914 Sparrows Pt. Rd</i>		d. STREET ADDRESS <i>#1 2914 SPARROWS PT. RD.</i>	
3. NAME OF DECEASED (Type or print) <i>Charlotte May Cousins</i>		4. DATE OF DEATH <i>APR. 20 1962</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 27 1898</i>
9. AGE (In years last birthday) <i>63 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seamstress</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Shirt</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Alexander De Vaughn</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Frances Frey</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-038523</i>	
17. INFORMANT <i>Emma Mack</i>		Address <i>P.O. Balto 19 md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Failure</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Arteriosclerotic Cardio Vascular Disease</i> DUE TO (c) <i>5 years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct. 28</i> , 19 <i>60</i> , to <i>Apr 20</i> , 19 <i>62</i> , that I last saw the deceased alive on <i>April 12</i> , 19 <i>62</i> , and that death occurred at <i>11:30</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Louis N. Torkin</i> M.D.		ADDRESS (Street, city or town, state) <i>6408 N. Pt. Rd. Balto 19 md</i>	
DATE SIGNED <i>4/20/62</i>			
PHYSICIAN'S NAME (Type) <i>LOUIS N. TORKIN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>APR 23, 1962</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>BALTO. NATIONAL</i>		22d. LOCATION (City, town, or county) (State) <i>BALTO. CO. MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Hoffmann</i>		ADDRESS <i>3218 HUDSON ST.</i>	
24a. REC'D BY REGISTRAR <i>APR 23 1962</i>		DATE	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

DE 11-11-21

END CONTENT

TAI-MI FORM

NO. 11-11-21

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		M		45		1876		BALTIMORE, MD	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1111 N. E. ST.		LABORER		HEART DISEASE		NATURAL		HOME	
DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		MINUTES OF DEATH		SECONDS OF DEATH	
11-11-21		10:30 AM		11:00 AM		11:30 AM		12:00 PM	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL PLACE	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
11-11-21		11-11-21		11-11-21		11-11-21		11-11-21	

1
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND
04198
CERTIFICATE OF DEATH
04195

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>				c. LENGTH OF STAY IN 1b <u>8 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>York Rd.</u>				e. STREET ADDRESS <u>York Rd.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elva P. Cox</u>				4. DATE OF DEATH Month Day Year <u>APRIL 22 1962</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 24 1892</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Electric Tools</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>White Hall, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>David Heaps</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMATION <u>Mrs. Eugene Miller, Parkton, Md. R.D.</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension</u> 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Vascular disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> to <u>APR 22, 1962</u> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>APR 22, 1962</u> , and that death occurred at <u>6:30</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>A. M. France</u> M.D.				22b. DATE SIGNED <u>4/22/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>				22d. ADDRESS <u>PARKTON, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 25, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Freedom Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>New Freedom, Penna.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein, New Freedom, Pa.</u>				25a. REC'D BY REGISTRAR <u>Arthur L. France</u>		25b. REGISTRAR'S SIGNATURE <u>DATE APR 24 '62</u>	

29150

PELM

TO HOSPITAL OR A Dying Physician: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04199

04196

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 22				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 22			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1 East Ship Road				d. STREET ADDRESS 1 East Ship Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Eason Last Cox				4. DATE OF DEATH Month April Day 8 Year 1962			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 22, 1893	
9. AGE (In years lost birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William W. Eason				14. MOTHER'S MAIDEN NAME Eliza Stephens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Louis T. Cox, 1 East Ship Road, Dundalk 22, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-Vascular Disease DUE TO Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 4-5 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Feb 1 1962 to April 8 1962 that (I) (we) last saw the deceased alive on 4/2/62 19 1962 , and that death occurred at 2 PM , from the causes and on the date stated above.							
22a. SIGNATURE M B Davis M.D.				22b. DATE SIGNED 4/9/62			
22c. PHYSICIAN'S NAME (Type) Melvin B. Davis, M.D.				22d. ADDRESS 6800 Morningson Road, Dundalk 22, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 4-10-62		23c. NAME OF CEMETERY OR CREMATORY Eason Cemetery		23d. LOCATION (City, town, or county) (State) South Mills, North Carolina	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, Baltimore 2				25a. REC'D BY REGISTRAR APR 11 '62		25b. REGISTRAR'S SIGNATURE Arthur S. [Signature]	

6133

CERTIFICATE OF DEATH

101130

[Faint, mostly illegible text and markings on a form, likely a death certificate. The text is mirrored across the page, suggesting bleed-through from the reverse side. Some legible fragments include:]

[Faint text at top right:] ...
[Faint text in middle:] ...
[Faint text at bottom:] ...

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04200

04197

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>rural - Cockeysville</u>		c. LENGTH OF STAY IN 1b <u>1 yr.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Md. Masonic Home</u>			d. STREET ADDRESS <u>2872 Hanford Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Mary Elizabeth Crawford</u>			4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1962</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 26, 1884</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore City, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13. FATHER'S NAME <u>John Huber</u>			14. MOTHER'S MAIDEN NAME <u>Mary Gorman</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Masonic Home - Records - Cockeysville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary sclerosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Generalized arteriosclerosis</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1961</u> to <u>April 1962</u> , that (I) (we) last saw the deceased alive on <u>April 20 1962</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Elizabeth B. Sherrill</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/20/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Elizabeth B. Sherrill M.D.</u>		22d. ADDRESS <u>Cockeysville Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Apr. 23, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc.</u>		ADDRESS <u>1217 St. Paul Street</u>		25a. REC'D BY REGISTRAR <u>DATE APR 24 '62</u>	25b. REGISTRAR'S SIGNATURE <u>Wm. L. Thane</u>

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William Cook, Inc.

1217 St. Paul Street

April 25, 1965

1217 St. Paul Street

William Cook, Inc.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04198

04201

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN IL 2 Hours 35 Min. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY - c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1437 Mulliken Court	
3. NAME OF DECEASED (Type or print) James First P.ERNELL Middle Cromwell Last		4. DATE OF DEATH April Month 6 Day 1962 Year	
5. SEX Male		6. COLOR OR RACE Negro	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 5, 1913	
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Paper Box Factory	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Cromwell		14. MOTHER'S MAIDEN NAME Lula Moore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 219-05-5309	
17. INFORMANT Clinical Records, Veterans Adm. Hospital, Fort Howard, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGIC PANCREATITIS DUE TO 581.0 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) CIRRHOSIS OF LIVER DUE TO (c) UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RIGHT LOWER LOBE PNEUMONIA		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 5, 1962 to 1962 , that (I) (we) last saw the deceased alive on April 6, 1962 , and that death occurred at 2:20 AM from the causes and on the date stated above.			
22a. SIGNATURE S. Sebastian Russo M.D. 22c. PHYSICIAN'S NAME (Type) S. SEBASTIAN RUSSO, M. D.		22b. DATE SIGNED 4/6/62 ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS VAH, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-10-62	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Locks, 1304 N. Central Ave. Balto. Md.		25a. REC'D BY REGISTRAR DATE APR 10 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Brown			

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(M)

Lawrence

Belmont

Belmont

Belmont

2 days of rain

July 1913

Veterans and National Guard

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TO HOSPITAL OR DURING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

04202

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04199

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY -		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3Y01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RIDGEWAY MANOR			d. STREET ADDRESS 803 WILDWOOD PKWY.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last LYDIA BURTON CROSS			4. DATE OF DEATH Month Day Year APRIL 21 1962		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 21, 1875		9. AGE (In years lost birthday) yrs. 86
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) KECIL CO., MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME ORLANDO BURTON		
14. MOTHER'S MAIDEN NAME MARY ELLEN MUMFORD			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.			17. INFORMANT Address MALCOLM J. COAN SAME		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory failure DUE TO 331 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Vascular Accident DUE TO (c) exit side hemiplegia					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized & severe					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from June 19, 1960 to 21 April 1962 that (I) (we) last saw the deceased alive on 21 April 1962 and that death occurred at M , from the causes and on the date stated above.					
22a. SIGNATURE William J. Bryson MD			22b. DATE SIGNED		22c. ADDRESS 4605 Edmonday ave
22d. PHYSICIAN'S NAME (Type) William J. Bryson			22e. ADDRESS 4605 Edmonday ave		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-25-62		23c. NAME OF CEMETERY OR CREMATORY ODD FELLOWS	
23d. LOCATION (City, town, or county) LAUREL, DELAWARE		(State)		23e. REC'D BY REGISTRAR DATE APR 25 '62	
24. FUNERAL DIRECTOR'S SIGNATURE JOHN O. MITCHELL & SONS, INC. 1900 EUTAW PLACE		ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

01100

CERTIFICATE OF DEATH

16502

NAME

DATE

AGE

SEX

PLACE OF BIRTH

DATE OF DEATH

1912

1875

WHITE

PLACE OF DEATH

CAUSE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>04203</div> <div>04200</div> </div> </div> <div> <div> <div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> <div>Baltimore</div> <div>MARYLAND</div> </div> <div> <div>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</div> <div>a. STATE</div> <div>Maryland</div> <div>b. COUNTY</div> <div>Baltimore</div> </div> </div>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street and address)								d. STREET ADDRESS			
8623 Chestnut Oak Avenue, Balto. 34								8623 Chestnut Oak Avenue 34			
e. IS RESIDENCE ON A FARM?				YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)				First Middle Last				4. DATE OF DEATH			
EDNA Clark CROW				Last				4 23 1962			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		July 25, 1905		56 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
Retired Homemaker								Baltimore, Maryland			
12. CITIZEN OF WHAT COUNTRY?				USA							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
John Butt				Elizabeth Hammel							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give number or dates of service)				17. INFORMANT Address			
No								Mr. William R. Burns-5713 Gwynn Oak Avenue #7			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease											
422.1 DUE TO (b)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Cirrhosis of liver											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Russell S. Fisher M.D.						CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED		
EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
Address (Street, city, town, or county)						4-23-62					
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)			
Burial				4-26-62		Loudon Park Cemetery		Baltimore, Maryland			
23. FUNERAL DIRECTOR						24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Wm J. Tucker & Sons Balto 17, Md.						DATE APR 24 '62		Arthur S. Thomas			

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04204

CERTIFICATE OF DEATH

Reg. Dis. 04201

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Rosedale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Rosedale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8304 Philadelphia Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>William</u> Last <u>CRUSSE</u>				4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1962</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 16, 1899</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Checker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Charles B. CRUSSE</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Sweeney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-07-1692</u>		INFORMANT Address <u>Lillian Crusse 8304 Philadelphia Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary Artery Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 18, 1962</u> to <u>April 18, 1962</u> , that I last saw the deceased alive on <u>April 18, 1962</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John H. Gish</u>				DATE SIGNED <u>4/19/62</u>			
PHYSICIAN'S NAME (Type) _____				ADDRESS (Street, city or town, state) <u>8019 Philadelphia Rd Baltimore, Maryland.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-21-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GARDENS OF FAITH</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip E. Couch</u>				ADDRESS <u>1211 Cheseco Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 23 '62</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

04204

CERTIFICATE OF DEATH



John Smith

John Smith

1890



John Smith

John Smith

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John Smith

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
e. COUNTY
Baltimore

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04205 CERTIFICATE OF DEATH 04202											
1. PLACE OF DEATH e. COUNTY Baltimore						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Armcast Nursing Home-812 Regester Ave.						d. STREET ADDRESS 2301 Kenoak Road #9					
3. NAME OF DECEASED (Type or print) Edna Dalsemer						4. DATE OF DEATH April 17 19 62					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Aug. 1. 1880		9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife						11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pennsylvania USA					
13. FATHER'S NAME Henry Dalsemer						14. MOTHER'S MAIDEN NAME Matilda Greenwald					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. 17. INFORMANT Mr. Gordon H. Dalsemer-2301 Kenoak Road #9					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 704.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Pemphigus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Cerebrovascular Disease 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (the hospital) attended the deceased from 10/15 1952 to 4/4 1962 that (I) (the) last saw the deceased alive on 4/4 1962 and that death occurred at 4:20 AM from the causes and on the date stated above.											
22a. SIGNATURE J. Elliot Levi						22b. DATE SIGNED M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 222 W. COLD SPRING LANE					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE THEREOF 4-18-62					
23c. NAME OF CEMETERY OR CREMATORY Balto. Hebrew Congregation						23d. LOCATION (City, town or county) 2100 Belair Rd, Balto. Md.					
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Schaefer						25a. REC'D BY REGISTRAR DATE APR 19 '62					
25b. REGISTRAR'S SIGNATURE Arthur S. Kline											

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TERRIST KEN

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APR 10 1952

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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04206

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04203

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE (RURAL)				c. LENGTH OF STAY IN 1b 74 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SHEPPARD YENOCIT PRATT HOSPITAL				d. STREET ADDRESS 4608 ROLAND AVE.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last HELEN LOUISE DAVIS				4. DATE OF DEATH Month Day Year APRIL 4 1962			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT 5, 1887	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER-RETIRED				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME HOWARD DAVIS				14. MOTHER'S MAIDEN NAME Ida Weldin WELDEN-IDA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT HOSPITAL CHART Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Heart Failure INTERVAL BETWEEN ONSET AND DEATH 5 days							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Oct 24 1961 to April 4 1962 , that (I) (we) last saw the deceased alive on April 4 1962 , and that death occurred at 24M , from the causes and on the date stated above.							
22a. SIGNATURE W.W. Elgin				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) W.W. Elgin M.D.				22d. ADDRESS Sheppard Pratt Hosp. Towson, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-7-62		23c. NAME OF CEMETERY OR CREMATORY Friends Burial Ground		23d. LOCATION (City, town, or county) (State) Balto. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickens				ADDRESS Balto. Md.		25a. REC'D BY REGISTRAR APR 5 '62 DATE	
						25b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

01200

CERTIFICATE OF DEATH

01200



1
M
12
1
2
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
AP
VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04204 CERTIFICATE OF DEATH 04204											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY -					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills				c. LENGTH OF STAY IN 1b 8 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 2				d. STREET ADDRESS 1710 Barclay Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rosewood State Training School						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Randolph, Jr. DEMINDS						4. DATE OF DEATH Month Day Year 4 3 19 62					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/12/50		9. AGE (In years last birthday) 11 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Randolph Deminds						14. MOTHER'S MAIDEN NAME Sarah Mae Wade					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Rosewood Records, Owings Mills, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490x Right side lobar pneumonia DUE TO (b) with lung abscess Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Spastic quadriplegia with symptomatic Epilepsy INTERVAL BETWEEN ONSET AND DEATH 5 days 8 days											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) unknown							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
19											
21. I certify that (H) (this hospital) attended the deceased from 7/6, 1961, to 4/3, 1962, that (H) (we) last saw the deceased alive on 4/3, 1962, and that death occurred at 10:20 p.m. on 4/5/62. The causes and on the date stated above.											
22a. SIGNATURE Harry G. Butler						22b. DATE SIGNED 4/5/62					
22c. PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.						22d. ADDRESS Owings Mills, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF April 9, 1962		23c. NAME OF CEMETERY OR CREMATORY Rosewood Cemetery				23d. LOCATION (City, town or county) (State) Owings Mills, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons						ADDRESS Reisterstown, Md.		25a. REC'D BY REGISTRAR DATE APR 11 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

(M)

(1)

U. S. Mine & Bone Refining Co.,
Batavia, N. Y.
April 2, 1905
Batavia, N. Y.

China Basin, N. Y.

Henry O. Smith, N. Y.

10:30 a.m.

10

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04205

04205

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ruxton c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2027 Skyline Road #4		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ruxton d. STREET ADDRESS 2027 Skyline Road #4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William K. Diehl		4. DATE OF DEATH April 19 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 4, 1913
9. AGE (In years last birthday) 48		10. IF UNDER 1 YEAR: Months 4 Days 18 Hours 15 Min. 10	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician-self		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William K. Diehl, Sr.		14. MOTHER'S MAIDEN NAME Charlotte Neumer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-36-5276	
17. INFORMANT Mrs. Ann L. Diehl		Address 2027 Skyline Rd., Ruxton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Aneurysm 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis CVD (c) Dissecting Aneurysm		INTERVAL BETWEEN ONSET AND DEATH Instant 10 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1945 to 4/19/62			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1945 , 19... to 4/19/62 , that (I) (we) last saw the deceased alive on 4/18/62 , and that death occurred at 6:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE W. H. [Signature]		22b. DATE SIGNED 4/19/62	
22c. PHYSICIAN'S NAME (Type) W. H. [Signature]		22d. ADDRESS 14 E. Eager St. Baltimore, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-23-62	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery	23d. LOCATION (City, town or county) (State) Woodlawn, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Jackson & Sons Baltimore, Maryland		25. REC'D BY REGISTRAR APR 23 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



100-200

DEPARTMENT OF HEALTH

100-200

U.S. DEPARTMENT OF HEALTH



100-200

1
FOR STATE
HEALTH DEPT
M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

OP

04209

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04206

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Md b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2148 Lorraine Ave		d. STREET ADDRESS 2148 Lorraine Ave	
3. NAME OF DECEASED (Type or print) Mary ETTA Doering		4. DATE OF DEATH April 21, 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 1, 1922
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	9. AGE (In years last birthday) 40 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLARD CANDLER		14. MOTHER'S MAIDEN NAME MAUD. MESSER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214-14-9362	
17. INFORMANT Paul Doering, 2148 Lorraine Ave		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound in chest # 12 Shot Gun DUE TO (b) 976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Shot herself while lying in bed with #12 Shot gun		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Shot herself while lying in her bed with # 12 shot gun		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) evidently pulled trigger with her toes	
20c. TIME OF INJURY Month, Day, Year 11-15 P.M. 4-21-62		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woodlawn		20f. (City or town) (County) (State) Baltimore Co. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Geo. S.M. Kieffer		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Geo. S.M. Kieffer M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED APR 24 '62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-25-1962	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or country) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR G. Howard Strong 3207 W. North Ave.,		24a. REC'D BY REGISTRAR APR 24 '62	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

04308

04308

Belmont

Belmont

Woodburn

Woodburn

2138 Lorraine Ave

2138 Lorraine Ave

Male

Female

Female

Male

Male

April 21, 1968

WILLARD CANDLER ROAD, W-282

2138 Lorraine Ave

2138 Lorraine Ave

One shot wound in chest. 12 inch rib

That breast while lying in bed with his gun
That breast while lying in bed with his gun
That breast while lying in bed with his gun

11-17-68, 11-17-68

Woodburn, Baltimore Co. MD

2138 Lorraine Ave, W-282

2138 Lorraine Ave, W-282

Woodburn

Woodburn

2138 Lorraine Ave, W-282

2138 Lorraine Ave, W-282

1
FOR STATE
HEALTH DEPT. (M)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04207											
1. PLACE OF DEATH a. COUNTY <u>BALTO</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN lb <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>In front of #5 Kershaw Blvd.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>NO RECORD</u>					
3. NAME OF DECEASED (Type or print) <u>Charles H Easterday</u>						4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1962</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 10 1906</u>		9. AGE in years (last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>17</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Circular Distributor</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>					
11. BIRTHPLACE (State or foreign country) <u>USA</u>						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>William H Easterday</u>						14. MOTHER'S MAIDEN NAME <u>Laura J Haller</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>None</u>					
17. INFORMANT <u>Mary Lohman 10 Mc Keldens Boonsboro</u>						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420. DUE TO (b) <u>A-S-C-V Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>None</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>None</u>					
20a. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>0</u>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20d. (City or town) <u>None</u>		20e. (County) <u>None</u>		20f. (State) <u>None</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>M.B. Davis</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>M.B. Davis MD</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>4/21/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Middleton Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Middleton Md</u>	
23. FUNERAL DIRECTOR <u>Best Funeral Home Boonsboro Md</u>						24a. REC'D BY REGISTRAR <u>APR 23 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

2
bpo

14805

1950



1950

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04211 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04208

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 120 Patapsco Ave.				d. STREET ADDRESS 120 Patapsco Ave.			
3. NAME OF DECEASED (Type or print) George Ehrbaker (A.K.A. Baker)				4. DATE OF DEATH April 19 19 62			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Layer				11b. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) 73 yrs.	
13. FATHER'S NAME Philip Ehrbaker				14. MOTHER'S MAIDEN NAME Eva von Brunen		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				17. INFORMANT Philip H. Ehrbaker, 2715 Margate Rd.-22			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 155.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) Carcinoma of Liver & Biliary System				INTERVAL BETWEEN ONSET AND DEATH 6-8 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				2Db. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None			
2Dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE M B Davis				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Melvin B. Davis, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 4/25/62			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4-23-62		22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		22d. LOCATION (City, town, or country) (State) Baltimore County, Md.	
23. FUNERAL DIRECTOR Ullrich Funeral Home, Dundalk, Md.				24a. REC'D BY REGISTRAR APR 25 '62			
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

RECEIVED
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1950

NEW YORK



1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04209

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town). <u>Baltimore</u>		c. LENGTH OF STAY in 1b <u>5 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6630 Marrott Ave</u>		d. STREET ADDRESS <u>1 6630 Marrott Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MILLARD N. EHRMAN</u>		4. DATE OF DEATH Month Day Year <u>APRIL 7 19 62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 13, 1910</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>19 62</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Financial Loans</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt. Administration</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Late Ansel Ehrman</u>		14. MOTHER'S MAIDEN NAME <u>Late Bessie Nusbaum</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES.</u> <u>W.W.II</u>		16. SOCIAL SECURITY NO. <u>337-01-7007</u>	
17. INFORMANT <u>Mrs. Betty Ehrman - Same</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic Carcinoma</u> DUE TO <u>153.9</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Carcinoma colon</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3-4 mths</u> <u>yr?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 4/5</u> , 19 <u>62</u> , to <u>4/7</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>4/5</u> , 19 <u>62</u> , and that death occurred at <u>8 PM</u> , from the causes and on the data stated above.			
22a. SIGNATURE <u>Maurice Feldman Jr.</u> M.D.		22b. DATE SIGNED <u>4/7/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>MA Maurice J. Feldman Jr.</u>		22d. ADDRESS <u>2 E Read St</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>4/8/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Sol L. Linnick & Bros.</u>		25a. REC'D BY REGISTRAR <u>APR 11 '62</u>	
ADDRESS <u>6010 Reisterstown Rd</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	

01299

CERTIFICATE OF DEATH

1910

14

March 12, 1910

That I, the undersigned, a duly qualified physician, do hereby certify that on the day and date above written, I examined the body of the deceased, and found that the cause of death was as stated on the certificate of death, and that the death was due to natural causes.

Witness my hand and seal this 12th day of March, 1910.

Dr. J. C. [Signature]

Dr. [Signature]

04213

CERTIFICATE OF DEATH

Reg. Dist. No.

04210

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Towson		c. LENGTH OF STAY IN 1b Two (2) years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Pearl Blanche Eichhorn		4. DATE OF DEATH Month Day Year April 8 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1884
9. AGE (In years last birthday) yrs. 77		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Deaver		14. MOTHER'S MAIDEN NAME Elizabeth Burton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Donna Barrett, R.N., 1439 Burton Ave		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS & HYPERTENSION DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PEPTIC ULCER, CONGESTIVE HEART FAILURE		INTERVAL BETWEEN ONSET AND DEATH 2 WKS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/22 , 19 59 , to 4/8 , 19 62 , that I last saw the deceased alive on 4/8 , 19 62 , and that death occurred at 9:33 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE T.C. Siwinski		ADDRESS (Street, city or town, state) 206 W. Pennsylvania Avenue DATE SIGNED 4/9/62	
PHYSICIAN'S NAME (Type) Thaddeus C. Siwinski, M.D.		Towson 4, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-11-62	22c. NAME OF CEMETERY OR CREMATORY Lorraine Park	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson Inc.		ADDRESS Towson 4, Maryland	
24a. REC'D BY REGISTRAR APR 11 1962		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10-13-10

CERTIFICATE OF DEATH

10-13-10

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 18

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Date of death: <u>October 13, 1910</u></p>	
<p>3. Place of death: <u>Home</u></p>		<p>4. Age: <u>45</u></p>	
<p>5. Sex: <u>Male</u></p>		<p>6. Race: <u>White</u></p>	
<p>7. Occupation: <u>Teacher</u></p>		<p>8. Cause of death: <u>Heart Disease</u></p>	
<p>9. Duration of illness: <u>2 weeks</u></p>		<p>10. Medical attendant: <u>Dr. J. Smith</u></p>	
<p>11. Burial place: <u>Catholic Cemetery</u></p>		<p>12. Signature of physician: <u>[Signature]</u></p>	
<p>13. Date of burial: <u>October 15, 1910</u></p>		<p>14. Signature of registrar: <u>[Signature]</u></p>	

TO HOSPITAL death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04211

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 5yr11mth12dys			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Spencer			4. DATE OF DEATH April 23 1962				
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-19-1888		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired watchman		10b. KIND OF BUSINESS OR INDUSTRY Pa. RR		11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Louis Ensor				14. MOTHER'S MAIDEN NAME Elizabeth Hutchinson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 717-07-6868		17. INFORMANT Address Records: Spring Grove State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b) Adhesive pericarditis; unknown etiology (c) Cardiac hypertrophy and dilatation PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 5 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 4 56 to April 23 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 23 1962 , and that death occurred at 8:10 a.m. from the causes and on the date stated above.							
22a. SIGNATURE Stella Wachslar				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 4-23-62		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				22d. ADDRESS Spring Grove State Hospital Catonsville, Maryland			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 26, 1962		23c. NAME OF CEMETERY OR CREMATORY Monkton Meth. Cemetery Monkton, Md.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE J. J. Slater New Freedom, Pa.				25a. REC'D BY REGISTRAR APR 27 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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SS lrrqA

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

04215
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04212
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2014 Rockwell Avenue</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>2014 Rockwell Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) <u>Charles V. Ernest, Sr.</u>		4. DATE OF DEATH <u>April 23 1962</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 27, 1898</u>		9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-V. Pres.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pressmans Union</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>											
13. FATHER'S NAME <u>Charles W. Ernest</u>				14. MOTHER'S MAIDEN NAME <u>?</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give year or dates of service) <u>World War I</u>								16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mr. Charles V. Ernest, Jr.</u> Address <u>2014 Rockwell Avenue</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> 321X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized Atherosclerosis</u> (a), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <u>5 Hours</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Generalized Atherosclerosis</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that (I) <u>this hospital</u> attended the deceased from <u>Jan 4/23</u> 19 <u>60</u> to <u>4/23</u> 19 <u>62</u> , that (I) <u>was</u> last saw the deceased alive on <u>4/23</u> 19 <u>62</u> , and that death occurred at <u>6:55 PM</u> from the causes and on the date stated above.																							
22a. SIGNATURE <u>James Nolan</u>				M.D. <u>SS NO LAN</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>4/24/62</u>											
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>1 Mellow Hill Ave Ball A Md.</u>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>4-26-62</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J Sackner & Sons</u>				ADDRESS <u>Baltimore, Md.</u>				25a. REC'D BY REGISTRAR <u>APR 27 '62</u>				25b. REGISTRAR'S SIGNATURE <u>1 E. Huns</u>											

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TO HOSPITAL 2. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04216					04213				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY Baltimore					a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills					b. COUNTY Montgomery				
c. LENGTH OF STAY IN 1b 7 mos. 10 da.					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rosewood State Training School					d. STREET ADDRESS Walter Reed Army Hospital				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last Lucinda Faye EVANS					Month Day Year 4 15 62				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/21/61		9. AGE (In years last birthday) yrs. Months Days 11 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dependent		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Everoux, France				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Morton Evans					14. MOTHER'S MAIDEN NAME Judith Carol Young (Evans)				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. none				
17. INFORMANT Rosewood Records, Owings Mills, Maryland					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia DUE TO (b) Acute bronchitis DUE TO (c) Arnold Chiari malformation (hydrocephalus, non-communicating; meningomyelocele).									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
Liekenschadel anomaly of the skull. Meningitis (pseudomonas aeruginosa)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (u) (this hospital) attended the deceased from 9/5 to 4/15 , 19 62 , that (w) (we) last saw the deceased alive on 4/15 , 19 62 , and that death occurred at 6:55 P.M. on the causes and on the date stated above.									
22a. SIGNATURE Harry G. Butler M.D.					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.					22d. ADDRESS Rosewood Lane, Owings Mills, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
23b. DATE THEREOF 4/18/62									
23c. NAME OF CEMETERY OR CREMATORY Rosewood Cemetery									
23d. LOCATION (City, town or county) (State) Owings Mills, Md.									
24. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons									
ADDRESS Reisterstown, Md.									
25a. REC'D BY REGISTRAR DATE APR 23 '62									
25b. REGISTRAR'S SIGNATURE Arthur S. Kline									

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© 2000 Blackwell Science Ltd

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1994

Henry C. Bell, Jr.

U. S. Office of Naval Intelligence

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after call.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
TITIAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04217

04214

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Penwood Terrace c. LENGTH OF STAY IN 1b 25 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Res., 8603 North Point Road, 19, Md.		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Penwood Terrace d. STREET ADDRESS 8603 North Point Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GRACE Ellen Ewing 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH May 1, 1892 WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH Month 4 - Day 4 - Year 1962 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Alco Alford		14. MOTHER'S MAIDEN NAME Louisa Walters	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None 17. INFORMANT Address Mrs. Lucille Sherrow P.O. Box 183 Ft. Howard, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial insufficiency 4-20-62 DUE TO (b) Arteriosclerotic Heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Jack Collins		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4-4-62 Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) 4-7-1962		22b. DATE THEREOF Burial	
22c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		22d. LOCATION (City, town, or country) (State) Washington Blvd. Md.	
23. FUNERAL DIRECTOR JOHN J. DUDA 7922 Wise Ave. 22, Md.		24a. REC'D BY REGISTRAR APR 5 '62 24b. REGISTRAR'S SIGNATURE Carlton E. H...	

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Grace Ellen Young

10/11/1915

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04218

04215

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY -	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Reisterstown		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 2	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bent Nursing Home, 12020 Reisterstown Road		d. STREET ADDRESS 621 East Biddle Street	
3. NAME OF DECEASED (Type or print) MARGARET S. FAGERLAND		4. DATE OF DEATH April 18 1962	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 19, 1878
9. AGE (In years last birthday) yrs. 83		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. May Fischer, 3005 Kentucky Avenue Zone 13		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO SCLEROTIC C.V. DISEASE DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 HRS YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/5 , 19 62 , to 4/18 , 19 62 , that (I) (we) last saw the deceased alive on 4/17 , 19 62 , and that death occurred at 7:50 AM , from the causes and on the date stated above.			
22a. SIGNATURE Martin E. Strobel		22b. DATE SIGNED 4/18/62	
22c. PHYSICIAN'S NAME (Type) MARTIN E. STROBEL		22d. ADDRESS REISTERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-21-62	
23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery		23d. LOCATION (City, town or county) (State) Taylor Ave & Dalesford Rd	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		24. ADDRESS	
25a. REC'D BY REGISTRAR APR 23 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hays	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
04216

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk (22)				c. LENGTH OF STAY IN 1b 30 years			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 120 Kinship Road				d. STREET ADDRESS 120 Kinship Road			
3. NAME OF DECEASED (Type or print) PETER E. FAHEY				4. DATE OF DEATH April 18th, 1962			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 18, 1882	
9. AGE (In years last birthday) 79 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heater		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Patrick Fahey				14. MOTHER'S MAIDEN NAME Catherine Needham			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 213-07-0649		17. INFORMANT Maude T. Fahey same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A-S-C-V DUE TO Disease (c) _____				INTERVAL BETWEEN ONSET AND DEATH _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Melvin B. Davis, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER Melvin B. Davis, M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
NAME (Type) Melvin B. Davis, M.D.				ADDRESS (Street, city, town, or county) Dundalk 22, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/23/62		22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		22d. LOCATION (City, town, or country) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR Walter Brooks Bradley, Inc., Dundalk 22, Md.				24a. REC'D BY REGISTRAR APR 23 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04217

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 407 Forest Lane		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Md b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 407 Forest Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Flossie May Faidley		4. DATE OF DEATH April 24, 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1884 9. AGE (In years last birthday) 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home duties		10b. KIND OF BUSINESS OR INDUSTRY Home	11. PLACE OF BIRTH (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Wyncoop Dickey	
14. MOTHER'S MAIDEN NAME Nettie Gardner		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. John W. Faidley		17. INFORMANT John W. Faidley Address 407 Forest Lane 28	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary heart disease DUE TO Cardio vascular disease, Arterio sclerosis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. Cardio vascular disease, Arterio sclerosis DUE TO Cardio vascular disease, Arterio sclerosis DUE TO Cardio vascular disease, Arterio sclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Geo. S. M. Kieffer		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED \$-23-62	
Address (Street, city, town, or county) lolo Leeds Ave			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/26/62	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemty.		22d. LOCATION (City, town, or country) (State) Balto. Md.	
23. FUNERAL DIRECTOR Witzke F.D. 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR APR 26 '62	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Klaus	

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John A. Feltz, 107 Forest Lane, 25

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH						04218					
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balto.					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Reisterstown						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Reisterstown					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Old Hanover Road						d. STREET ADDRESS Old Hanover Road					
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Richard J. Farace						4. DATE OF DEATH April 13, 19 62					
5. SEX Male						6. COLOR OR RACE White					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>						8. DATE OF BIRTH May 30, 1896					
9. AGE (In years last birthday) 65 yrs.						10. IF UNDER 1 YEAR Months Days					
11. IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer						10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) Baltimore City						12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Vincent Farace						14. MOTHER'S MAIDEN NAME Rose A. Scalco					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWL						16. SOCIAL SECURITY NO. 216-01-6859					
17. INFORMANT Richard J. Farace						Address Easton Penna.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive B rain Damage DUE TO (b) Fractured Skull Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Auto driven by deceased struck by train					
20c. TIME OF INJURY Month, Day, Year 2:20 p.m. 4/13/ 19 62						20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street						20f. (City or town) (County) (State) Reisterstown, Balto., Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ACTUAL SIGNATURE Martin E. Strobel M.D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type) Dr. Martin E. Strobel Reisterstown, Balto. Co. DATE SIGNED 4/14/62											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF April 16, 62					
22c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial						22d. LOCATION (City, town, or country) (State) Finksburg, Md.					
23. FUNERAL DIRECTOR J. F. Eline & Sons						ADDRESS Reisterstown, Md.					
24a. REC'D BY REGISTRAR DATE APR 17 '62						24b. REGISTRAR'S SIGNATURE Arthur L. Hines					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
04222					04219				
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 60 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville (rural)				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION All Saint's Convent					d. STREET ADDRESS Hilton Ave. (extended)			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sister Agnes of all Saint's			First Middle Last		4. DATE OF DEATH Month Day Year April 23, 19 62				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 15, 1869		9. AGE (In years last birthday) 92 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Professed Sister			10b. KIND OF BUSINESS OR INDUSTRY Sisters of the poor			11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Rev. William George Farrington					14. MOTHER'S MAIDEN NAME Anne W. Kip				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Address All Saint's Convent Catonsville - 28, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO 4-22-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) generalized arteriosclerosis DUE TO (c) 1037.								INTERVAL BETWEEN ONSET AND DEATH 2 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 4-1-1940 to 4-23-1962 that (I) (we) last saw the deceased alive on 4-21-1962 and that death occurred at 11:45 AM from the causes and on the date stated above.									
22a. SIGNATURE Wilmer K. Gallagher					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/24/62		
22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher M. D.					22d. ADDRESS 2609 Frederick Ave. Catonsville - 28, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 4/25/1962		23c. NAME OF CEMETERY OR CREMATORY All Saint's Convent Cem.			23d. LOCATION (City, town, or county) (State) Catonsville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Easton Funeral Home					ADDRESS Catonsville, Md.		25a. REC'D BY REGISTRAR DATE APR 27 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Kneiss

01519

CERTIFICATE OF BIRTH

01519

Birthplace

Birthplace

Birthplace

Catonsville (former)

60 yrs.

Catonsville

Hilton Ave. (extended)

All Saint's Convent

April 23, 1869

Sister Anne of All Saint's

92

Oct. 15, 1869

Female White

U. S. A.

Professed Sister Sisters of the poor New Jersey

Rev. William George Livingston Anne W. Lip

All Saint's Convent Catonsville - 28, Md.

No

Supplied by the
Birthplace

Catonsville, Md.

All Saint's Convent

1/23/1902

Female

2609 Frederick Ave. Catonsville - 28, Md.

Wilmer H. Callender M. D.

04223

CERTIFICATE OF DEATH

Reg. Dist. No. 04220

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1001 W. Joppa Rd. Mission Helpers Convent		d. STREET ADDRESS 1001 West Joppa Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sister Mary Isaia (Finneran)		4. DATE OF DEATH April 7, 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20, 1875
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nun		10b. KIND OF BUSINESS OR INDUSTRY Convent	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Patrick Finneran		14. MOTHER'S MAIDEN NAME Mary Hanley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Convent Records, 1001 W. Joppa Road		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Lung DUE TO Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary Carcinoma of Breast DUE TO Breast (c) 3 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 mos.			
INTERVAL BETWEEN ONSET AND DEATH 6 mos.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 24, 1949 to April 7, 1962 , that I last saw the deceased alive on April 24, 1962 , and that death occurred at Md. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. O'Donnell		ADDRESS (Street, city or town, state) 7501 York Road	
DATE SIGNED 4/19/62			
PHYSICIAN'S NAME (Type) Charles F. O'Donnell, M.D.		Towson 4, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/10/62	
22c. NAME OF CEMETERY OR CREMATORY Convent Cemetery		22d. LOCATION (City, town, or county) (State) 1001 W. Joppa Rd. Towson, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Vernon Lemmon		ADDRESS 4611 Park Heights, Balto.	
24a. REC'D BY REGISTRAR APR 10 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

62933

MAYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS	
1. NAME OF DECEASED JAMES W. TOWNSON	
2. SEX Male	
3. AGE 40	
4. DATE OF DEATH April 10, 1963	
5. PLACE OF DEATH New York City	
6. CAUSE OF DEATH Heart Disease	
7. MANNER OF DEATH Natural	
8. SIGNATURE OF DECEASED James W. Townson	
9. SIGNATURE OF WITNESSES John A. Townson	
10. SIGNATURE OF PHYSICIAN Dr. J. W. Townson	
11. SIGNATURE OF CLERK John A. Townson	
12. SIGNATURE OF REGISTRAR John A. Townson	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04224

04221

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PERRY HALL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Perry Hall</u>	
c. LENGTH OF STAY in lb <u>2 1/2 YRS</u>		d. STREET ADDRESS <u>Joppa Road.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDMUND J FISCHER</u>		4. DATE OF DEATH Month Day Year <u>April 24 1962</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1-1876</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick Fischer</u>		14. MOTHER'S MAIDEN NAME <u>Theresa Pötsch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>220-34-573</u>	
17. INFORMANT <u>Walter Fischer</u> Address <u>Joppa Rd. Perry Hall Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Artherosclerotic coronary vasc. disease</u> (c) <u>10 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>immed.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1950</u> , to <u>April 24, 1962</u> , that (I) (we) last saw the deceased alive on <u>Apr 24 1962</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Louis Semenovoff</u> M.D.		22b. DATE SIGNED <u>4/25/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>LOUIS SEMENOFF</u>		22d. ADDRESS <u>2108 OREMS RD, BACTO 20, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Apr 27-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Zion Luth. Cem</u>		23d. LOCATION (City, town or county) (State) <u>Balto Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Fun'l Home</u>		25a. REC'D BY REGISTRAR <u>APR 30 '62</u>	
		25b. REGISTRAR'S SIGNATURE <u>Wm L. Frank</u>	

04221

CERTIFICATE OF DEATH

04221

M

My medical certificate
has been submitted to the
proper authorities and
has been approved.

for 30 days

John H. Henshaw
Louis Henshaw

Notary Public

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04225

CERTIFICATE OF DEATH

04222

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson Balto. County c. LENGTH OF STAY IN 1b 6 weeks		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Penna. b. COUNTY Lancaster c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lancaster, Lancaster Co. Penna. d. STREET ADDRESS 119 Juniata St. Lancaster e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna May Fisher		4. DATE OF DEATH Month Apr. Day 18 Year 1962	
5. SEX F.	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 2, 1879
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 75 Days X Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State, or foreign country) Penna. Strasburg, Lancaster Co.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Mowery		14. MOTHER'S MAIDEN NAME Mary McCleary	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Paul Rife		Address 1710 Edgewood Rd. Towson, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) uremia DUE TO (b) Hemiplegia DUE TO (c) Arteriosclerosis with Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. INTERVAL BETWEEN ONSET AND DEATH 4 days 10 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) no			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/1/62 to 4/1/62 ; that (I) (we) last saw the deceased alive on 4/1/62 , and that death occurred at 2 PM , from the causes and on the date stated above.			
22a. SIGNATURE Wm. Conway M.D.		22b. DATE SIGNED 4/18/62	
22c. PHYSICIAN'S NAME (Type) W. M. Conway M.D.		22d. ADDRESS 8358 Loch Raven Blvd. Towson & Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 4/18/62	23c. NAME OF CEMETERY OR CREMATORY Riverview Burial Park	23d. LOCATION (City, town or county) (State) Strasburg, Penna.
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc. 1050 York Rd.		25a. REC'D BY REGISTRAR APR 23 '62	25b. REGISTRAR'S SIGNATURE Arthur L. Kline

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

04222

04222

Baltimore

Penna. Lancaster

Townson Baltimore County 6 weeks Kentucky Lancaster Co. Penna.

1710 Ridgewood Road Towson, Md. 110 Towson St. Lancaster

82	Apr. 18	Fisher	May	Anna	White	x	Oct. 2, 1879	82
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U.S.	Penns. Co.	Strasburg, Lancaster Co.	none	John Kowaly
------	------------	--------------------------	------	-------------

no	Mrs. Paul White, 1710 Ridgewood Rd. Towson, Md.	Mary McCleary
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Removal #18/82 Riverview Burial Park Strasburg, Penna.
Wm. Cook-Towson, Inc. 1050 York Rd. #

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04226

04223

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Cockeysville</u>		c. LENGTH OF STAY IN 1b <u>most of life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BESSIE REBECCA FORD</u> Middle Last		4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 21, 1888</u>
9. AGE (In years lost birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George McFATRIDGE</u>		14. MOTHER'S MAIDEN NAME <u>LAURA VIRGINIA SLADE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Elsworth Ford</u>		Address <u>Cockeysville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anemia, coronary sclerosis</u> DUE TO <u>420</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>cardiovascular disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1947</u> to <u>April 11, 1962</u> , that (I) (we) last saw the deceased alive on <u>April 11, 1962</u> , and that death occurred at <u>8:45 P.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Elizabeth B. Sherrill M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Elizabeth B. Sherrill M.D.</u>		22d. ADDRESS <u>Cockeysville Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4-14-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Poplar Grove Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Cockeysville Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks Funeral Service, Inc. Towson 4, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 16 '62</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

(M)

X

(1)

0

1

1883

CERTIFICATE OF DEATH

1883

George W. Felt, Jr.
born [illegible]
died [illegible]
cause of death [illegible]
buried [illegible]
[illegible text continues in several lines]

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 501 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04227

CERTIFICATE OF DEATH

04224

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		Items 13 & 14 Film G311 4/12/62 mh Items 8 & 9 Film G311 4/18/62 mh		USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Overlea</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Overlea</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>23 Leslie Ave.</i>				d. STREET ADDRESS <i>23 Leslie Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>L.</i> Last <i>Forrest</i>		4. DATE OF DEATH Month <i>4</i> Day <i>7</i> Year <i>19 62</i>					
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>May 11, 1888</i>		9. AGE (In years last birthday) <i>73</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Henry Wehr</i>		14. MOTHER'S MAIDEN NAME <i>Mary E. Lewis</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>P. Vernon Forrest Sr.</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>4-20-62</i> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <i>Coronary Thrombosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes Mellitus</i>				INTERVAL BETWEEN ONSET AND DEATH <i>7 hours</i> <i>uncertain</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1959</i> to <i>4-7</i> , 1962, that (I) (was) last saw the deceased alive on <i>4-7</i> , 1962, and that death occurred at <i>1 A.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>Paul G. Mueller</i>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>4-7-62</i>	
22c. PHYSICIAN'S NAME (Type) <i>PAUL G. MUELLER</i>		22d. ADDRESS <i>6411 Belair Rd Balt. 6 Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>4-10-62</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lake View Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Baltimore, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>L. J. Ruck Inc.</i>		ADDRESS <i>5305 Harford Road</i>		25a. REC'D BY REGISTRAR DATE <i>APR 9 '62</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

04531

04531



1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

04228

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04225

| | | | | | |
|---|---|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SPARROWS POINT
c. LENGTH OF STAY IN TB 45YRS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1018 I STREET | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MD
b. COUNTY BALTIMORE
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SPARROWS POINT
d. STREET ADDRESS 1018 I STREET | | |
| 3. NAME OF DECEASED
(Type or print) PAUL FOSTER | | | 4. DATE OF DEATH
Month 18 Day APRIL Year 19 62 | | |
| 5. SEX MALE | 6. COLOR OR RACE C | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4 JUNE 1886 | 9. AGE (In years last birthday) 75 yrs. | IF UNDER 1 YEAR
Months 75 Days 19 Hours 62 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL WORKER | | 10b. KIND OF BUSINESS OR INDUSTRY STEEL | | 11. BIRTHPLACE (State or foreign country) HALIFAX COUNTY, VA. | |
| 13. FATHER'S NAME JIM FOSTER | | 14. MOTHER'S MAIDEN NAME FANNIE FOSTER | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 216-09-5434A | | 17. INFORMANT MARY WILLIE FOSTER(W) Address 1018 I ST. SPARROWS PT. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ① H-S-C-V Disease
422.1 DUE TO Bi-lateral Pyelonephritis & LRV
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Nephrolithiasis
(b)
(c) gsm | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) As | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. 19
p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE M B Davis | | M.D. DR. MELVIN B. DAVIS | | DATE SIGNED | |
| EXAMINER'S NAME (Type) DR. MELVIN B. DAVIS | | Address (Street, city, town, or county) 6800 MORNINGTON RD. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 22 APRIL 62 | 22c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM'L PK. | | 22d. LOCATION (City, town, or country) (State) BALTO. COUNTY, MD. | |
| 23. FUNERAL DIRECTOR CHARLES G. COOPER | | ADDRESS 512 CARROLLTON AV. BALTO. MD. | | 24a. REC'D BY REGISTRAR APR 19 62 | 24b. REGISTRAR'S SIGNATURE Arthur L. Harris |

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TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate will be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04229

04226

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Virginia b. COUNTY | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Chincoteague | |
| c. LENGTH OF STAY IN IS
89 Days | | d. STREET ADDRESS
307 Church Street | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Veterans Administration Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First MILTON Middle H. Last FOXWELL | | 4. DATE OF DEATH
Month APRIL Day 28TH Year 19 62 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2/20/17 |
| 9. AGE (In years last birthday)
45 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S. Naval Base | |
| 11. BIRTHPLACE (County & State, or foreign country)
Somerset, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Hayes Foxwell | | 14. MOTHER'S MAIDEN NAME
Annie Dashields | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WW II | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Clin. Rec. VAH, Fort Howard, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA
DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. }
(b) BRONCHOGENIC CARCINOMA
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH
2 DAYS
3 MONTHS | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (this hospital) attended the deceased from Jan. 29 1962 to April 28 1962 that (we) last saw the deceased alive on April 28 1962 , and that death occurred at 1:35 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Joshua A. Smith</i> M.D. | | 22b. DATE SIGNED
4/28/62 | |
| 22c. PHYSICIAN'S NAME (Type)
JOSHUA A. SMITH, M.D. | | 22d. ADDRESS
VAH, FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | 23b. DATE THEREOF
4-29-62 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Downing Cemetery | | 23d. LOCATION (City, town or county) (State)
Oak Hall, Virginia | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>Wm Cook Inc.</i> | | 25a. REC'D BY REGISTRAR
MAY 1 '62 | |
| ADDRESS
1217 ST PAUL ST, BALTO. | | 25b. REGISTRAR'S SIGNATURE
<i>Arthur S. Thomas</i> | |

MEDICAL CERTIFICATION

M

Baltimore

Fort Howard

89 Days

Virginia

Chinoctague

307 Church Street

Veterans Administration Hospital

MILTON

B.

FOURMILL

APRIL 28TH

62

White

White

2/20/17

15

Laborer

U.S. Naval Base

Bowenest, Maryland

U.S.A.

Hayes Townell

Amie Dashiels

Yes

WM II

Olivia, Rec. VAM, Fort Howard, Maryland

BRONCHOPNEUMONIA

BRONCHOPNEUMONIA CAROTINOM

2 DAYS

3 MONTHS

April 28 62

Jan. 22 1:32 PM 62

April 28 62

11

4/20/62

X

JOSHUA A. SMITH, M.D.

VAN, FORT HOWARD, MARYLAND

Removal

Bowling Cemetery

Oak Hall, Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04230

04227

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
e. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE Maryland b. COUNTY - | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Owings Mills | | c. LENGTH OF STAY IN lb
4 months | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 1, | | d. STREET ADDRESS
666 West Franklin Street | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Rosewood State Training School | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First Carolyn Middle - Last GAREY | | | | 4. DATE OF DEATH
Month 4 Day 2 Year 19 62 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
10/28/55 | |
| 9. AGE (In years last birthday)
6 yrs. | | IF UNDER 1 YEAR
Months 6 Days 4 | | IF UNDER 24 HRS.
Hours 19 Min. 62 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
dependent | | | | 10b. KIND OF BUSINESS OR INDUSTRY
none | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore City, Md. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
Carroll Shannon | | | | 14. MOTHER'S MAIDEN NAME
Barbara Ellen Garey Stokes | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service) - | | | | 16. SOCIAL SECURITY NO.
none | | | |
| 17. INFORMANT
Rosewood Records, Owings Mills, Md. | | | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Bilateral Broncho pneumonia
500X DUE TO Acute Bronchitis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Post-meningo-encephalitis with symptomatic
(c) encephalitis | | | | INTERVAL BETWEEN ONSET AND DEATH
1 day
7 days | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Post-meningo-encephalitis with symptomatic | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5 yrs - | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
encephalitis | | 20c. TIME OF INJURY Month, Day, Year
Hour e.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
Baltimore | | (County)
Md. | | (State)
Md. | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11/27 , 19 61 to 4/2 , 19 62 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4/2 , 19 62 , and that death occurred at 2:15 P.M. on the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Darryl G. Butler | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 3 April '62 | | | |
| 22c. PHYSICIAN'S NAME (Type)
Harry G. Butler, M.D. | | | | 22d. ADDRESS
Rosewood Lane, Owings Mills, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial Apr. 6 1962 | | 23b. DATE THEREOF
Apr. 6 1962 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cem | | 23d. LOCATION (City, town or county)
Baltimore Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Mrs. Kate R. Williams | | | | ADDRESS
322 ~ Sch. Rd. Md 23 | | 25a. REC'D BY REGISTRAR
APR 4 '62 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Thomas | | | | 25c. DATE
APR 4 '62 | | | |



1938

1938

Belmont

Belmont

William Miller

William Miller

Woodward State Training School

Woodward State Training School

Carroll

Carroll

Female

Female

Belmont

Belmont

Carroll

Carroll

Woodward State Training School

Woodward State Training School

Woodward State Training School

Post-graduate work with significant results

1938

1938

1938

1938

1938

1938

1938

Woodward State Training School

Woodward State Training School

Woodward State Training School

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04231

04228

| | | | | | | | |
|---|----------------------------------|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Balto.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>Balto.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Kingsville</u> | | c. LENGTH OF STAY IN 1b
<u>27 yrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Kingsville</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Box 477 Sunshine Ave</u> | | | | d. STREET ADDRESS
<u>Box 477 Sunshine Ave</u> | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Karl</u> Middle <u>A.</u> Last <u>Gabler</u> | | | | 4. DATE OF DEATH
Month <u>April</u> Day <u>7</u> Year <u>1962</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>May 8 1892</u> | | 9. AGE (In years last birthday)
<u>69</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Retired</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Germany</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Herman Oswald Gabler</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Baselle Snider Walther</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
<u>215079959</u> | | 17. INFORMANT
<u>Mary Gabler</u> Address <u>Box 477 Sunshine Ave</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ANGINA PECTORIS</u>
DUE TO <u>CORONARY THROMBOSIS (2)</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO <u>HYPERTENSIVE CARDIOVASCULAR DIS.</u>
DUE TO <u>HYPERTHYROIDISM</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE CAUSE OR CONDITIONS GIVEN IN PART I (a) <u>HYPERTROPHIC ARTHRITIS</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>16 yrs</u>
<u>14 yrs.</u>
<u>18 yrs.</u> | |
| | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9/16</u> to <u>4/1</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>3/31</u> 19 <u>62</u> and that death occurred at <u>8:30</u> A.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Clifford F. Hudson</u> | | | | 22b. ADDRESS
<u>FORK, MD.</u> | | 22c. PHYSICIAN'S NAME (Type)
<u>CLIFFORD F. HUDSON</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>APRIL 4 62</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>BELAIR MEMORIAL GARDENS</u> | | 23d. LOCATION (City, town, or county) <u>BELAIR</u> (State) <u>MD</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>W. J. Bros.</u> | | | | 25a. REC'D BY REGISTRAR
<u>APR 3 '62</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Howard</u> | |

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STATE OF NEW YORK

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04232

04229

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Haltershoppe</u>
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>1716 Wilson Ave.</u> | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE <u>Maryland</u>
b. COUNTY <u>Baltimore</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Haltershoppe</u>
d. STREET ADDRESS
<u>1716 Wilson Ave</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
|---|--|--|--|

| | | | |
|--|---|---|---|
| 3. NAME OF DECEASED
(Type or print) <u>Grace E Gerber</u>
First Middle Last | | 4. DATE OF DEATH
<u>April 18, 1962</u>
Month Day Year | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Jan-17-1897</u> |

| | | | |
|--|---|--|---|
| 9. AGE (In years last birthday)
<u>65 yrs.</u> | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Machine Operator - Factory</u> | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Baltimore, MD</u> | 11. BIRTHPLACE (County & State, or foreign country)
<u>USA.</u> |
|--|---|--|---|

| | | |
|--|---|---|
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA.</u> | 13. FATHER'S NAME
<u>George C. Miller</u> | 14. MOTHER'S MAIDEN NAME
<u>Annie T. Keller</u> |
|--|---|---|

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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> | 16. SOCIAL SECURITY NO.
<u>215-28-8903</u> | 17. INFORMANT
<u>HELEN E McINTYRE - SAME</u>
Address |
|---|--|---|

| | | |
|---|--|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 yrs.</u> |
|---|--|---|

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Diabetic Mellitus 15 yrs</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|---|--|--|

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|---|--|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |

| | |
|---|---|
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
|---|---|

21. I certify that (I) (the hospital) attended the deceased from Aug 19, 1948, **to** April 18, 1962, **that (I) (we) last saw the deceased alive on** April 14, 1962, **and that death occurred at** 3 P.M., **from the causes and on the date stated above.**

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| 22a. SIGNATURE
<u>C. Arthur Rosenberg M.D.</u> | 22b. DATE SIGNED
<u>4/20/62</u> |
| 22c. PHYSICIAN'S NAME (Type)
<u>C. ARTHUR ROSENBERG MD</u> | 22d. ADDRESS
<u>2436 Washington Blvd. Balto - 30, Md.</u> |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial, Apr. 20/62</u> | 23b. DATE THEREOF
<u>Apr. 20/62</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Heaton Park</u> | 23d. LOCATION (City, town or county) (State)
<u>Balto. Maryland</u> |
|---|---|---|---|

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| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>T. B. Wipert - 1300 Eutaw Pl.</u> | 25a. REC'D BY REGISTRAR
DATE <u>APR 23 '62</u> | 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kenna</u> |
|---|--|---|

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04233

CERTIFICATE OF DEATH

04230

| | | | |
|---|----------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Md b. COUNTY Balto | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Carney | | c. LENGTH OF STAY IN 1b
80 | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
9103 Old Harford Road | | d. STREET ADDRESS
9103 Harford Road | |
| 3. NAME OF DECEASED (Type or print)
CHARLES W. GERMAN | | 4. DATE OF DEATH
Month 4 Day 13 Year 1962 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11-22-1875 |
| 9. AGE (In years last birthday)
86 yrs. | | IF UNDER 1 YEAR
Months 8 Days 13 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY
Balto. Co. | |
| 11. BIRTHPLACE (County & State, or foreign country)
U S A | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 13. FATHER'S NAME
Howell P German | | 14. MOTHER'S MAIDEN NAME
Catherine P Stahl | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Mrs Ella M McKenna | | Address
9103 Old Harford Road (34) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute coronary occlusion
DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Arterio-sclerotic cardiovascular disease
DUE TO (c) 15 yrs. | | INTERVAL BETWEEN ONSET AND DEATH
15 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Feb. 1962 to April, 1962 ; that (I) (we) last saw the deceased alive on April, 1962 , and that death occurred April, 1962 , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Arthur S. Hanna | | 22b. DATE SIGNED
4/14/62 | |
| 22c. PHYSICIAN'S NAME (Type)
Arthur S. Hanna | | 22d. ADDRESS
8100 Harford Rd., Balto. 34, Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4-17-1962 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Hiss Cemetery | | 23d. LOCATION (City, town or county) (State)
Balto. Co Md | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Lassahn Funeral Home | | 24. ADDRESS
7401 Belair Road | |
| 25a. REC'D BY REGISTRAR
DATE APR 16 '62 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Hanna | |

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CHARLES

W. L. KENNAN

11-25-1935

11-25-1935

11-25-1935

Washington - D.C.

Washington - D.C.

See also a Bureau file on this case.

See also a Bureau file on this case.

See also a Bureau file on this case.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04234

04234

| | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; valid only if preceded by admission)
a. STATE Md. b. COUNTY Baltimore | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lakehurst | | c. LENGTH OF STAY IN 1b
8 Yrs | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lakehurst | | d. STREET ADDRESS
6016 Lakeview Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
6016 Lakeview Road | | | | 4. DATE OF DEATH
Month April Day 7 Year 1962 | | | | | |
| 3. NAME OF DECEASED (Type or print)
Louis T. Gotterman, Sr. | | | | 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
Mar. 6, 1896 | | | | 9. AGE (In years last birthday)
66 yrs. | | IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> | | IF UNDER 24 HRS.
Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Vice President Wholesale Hardware | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Anderson and Ireland | | 11. BIRTHPLACE (County & State, or foreign country)
Va. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
George L. Gotterman | | | | 14. MOTHER'S MAIDEN NAME
Catherine Ellenberger | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
Yes. W.W.1 | | | | 16. SOCIAL SECURITY NO.
212-07-6793 | | 17. INFORMANT
Mrs. M. Irene Gotterman Address 6016 Lakeview Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)
154X Adeno Carcinoma Reclun
DUE TO
Metastasis liver & Lungs
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.
DUE TO
(c) | | | | INTERVAL BETWEEN ONSET AND DEATH
Dec 1961 | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21. I certify that (I) (this hospital) attended the deceased from Dec 1961 to Apr 7, 1962 ; that (I) (we) last saw the deceased alive on April 6, 1962 , and that death occurred at 4 A.M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
W. Arthur Darby | | | | M.D.
817 Medical Arts Bldg April 7, 1962 | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4-10-1962 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn | | 23d. LOCATION (City, town or county) (State)
Woodlawn Md. | | 25a. REC'D BY REGISTRAR
DATE APR 10 '62 | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Howard Strong 3707 W. North Ave. | | | | ADDRESS | | 25b. REGISTRAR'S SIGNATURE
John L. Kline | | | |

1933

Bellevue

Bellevue

Bellevue Road

Louis

White

Bellevue Road

Bellevue

George H. Gottman

George H. Gottman

W.I.

W.I.

W.I.

1-10-1933

1-10-1933

1-10-1933

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04235

CERTIFICATE OF DEATH

Reg. Dist. No.

04232

| | | | |
|--|---------------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MARYLAND</u>
b. COUNTY <u>-</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>BALTIMORE 28</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>BALTIMORE</u> <u>3V01-4</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>HOUSE IN PINES</u> | | d. STREET ADDRESS
<u>TRUIERA APTS - LAKE DRIVE</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>LAWRENCE</u> Middle <u>GOLDHEIM</u> Last <u>-</u> | | 4. DATE OF DEATH
Month <u>4</u> - Day <u>11</u> - Year <u>1962</u> | |
| 5. SEX
<u>MALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>MAY 24, 1884</u> |
| 9. AGE (In years lost birthday)
<u>77</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>RETIRED</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>ATTORNEY</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>MISSOURI</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>NOT KNOWN</u> | | 14. MOTHER'S MAIDEN NAME
<u>NOT KNOWN</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>284-10-7615</u> | |
| 17. INFORMANT
<u>BELMA ROSENBERG</u> | | Address
<u>903 LAKE DRIVE</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio-Vascular Disease</u>
DUE TO
(c) <u>-</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>17 hrs.</u>
<u>10 hrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. <u>19</u>
p. m. <u>-</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>10-27, 1961</u> , to <u>4-10, 1962</u> that I last saw the deceased alive on <u>4-9, 1962</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>6209 Frederick Ave. Baltimore 28 - Md.</u>
DATE SIGNED <u>4-21-62</u> | | | |
| ACTUAL SIGNATURE <u>Wilmer K. Gallager</u> | | M.D. <u>6209 Frederick Ave. Baltimore 28 - Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallager, M.D.</u> | | <u>Baltimore 28 - Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 22b. DATE THEREOF
<u>4-13-1962</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>BALTO. HEBREW</u> | 22d. LOCATION (City, town, or county) (State)
<u>BALTO. MD</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Jack Lewis Inc - 3100 Eutanaw Place</u> | | 24a. REC'D BY REGISTRAR
DATE <u>APR 16 '62</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. Hanna</u> | | | |

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TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04233

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Howard | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Ellicott City | |
| c. LENGTH OF STAY in lb
3 Days | | d. STREET ADDRESS
43 Fells Ave | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Veterans Administration Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First JAMES Middle D Last GREENE | | 4. DATE OF DEATH
Month April Day 17 Year 1962 | |
| 5. SEX
Male | | 6. COLOR OR RACE
Colored | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
February 17, 1891 | |
| 9. AGE (In years last birthday)
71 yrs. | | 10. IF UNDER 1 YEAR
Months 71 Days 17 Hours 19 Min. 62 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY
Paper Mill | |
| 11. BIRTHPLACE (County & State, or foreign country)
Ellicott City, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 13. FATHER'S NAME
George Greene | | 14. MOTHER'S MAIDEN NAME
Agnes Brooks | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war and dates of service)
Yes WW I | | 16. SOCIAL SECURITY NO.
218-05-1120 | |
| 17. INFORMANT
Clinical Records VAH Fort Howard, Maryland | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BILATERAL LOBAR PNEUMONIA
490X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)
} DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Emphysema Bilateral; Pleural Adhesions Bil | | INTERVAL BETWEEN ONSET AND DEATH
3 days | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from April 14, 1962, to April 17, 1962, that (X) (we) last saw the deceased alive on April 17, 1962, and that death occurred at 2:55 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Sebastian Russo</i> | | 22b. DATE SIGNED
4/17/62 | |
| 22c. PHYSICIAN'S NAME (Type)
SEBASTIAN RUSSO, M.D. | | 22d. ADDRESS
VAH Ft Howard, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4-20-1962 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Western Star | | 23d. LOCATION (City, town or county) (State)
Catonsville
Baltimore, Maryland | |
| 24 FUNERAL DIRECTOR'S SIGNATURE
F. C. Higinbotham | | 25a. REC'D BY REGISTRAR
APR 23 '62 | |
| 25b. REGISTRAR'S SIGNATURE
<i>Arthur S. Hume</i> | | | |

M

James
York, Maine

3 days

Billings City

York's Administration Record

JAMES

CHURCH

North

11-82

Colonel (General)

February 17, 1891

London

Letter 111

March 10, 1891

U.S.A.

George Greene

1891

Vol I

1891-1892

Annual Record of the York House, Maine

RECEIVED YORK HOUSE

York's Administration Record

Handwritten signature

ST. JAMES LANE, N.Y.

Van B. House, Maine

Estimate
York, Maine

York's Administration Record
1891-1892

York's Administration Record

01831

04387



275 S. Robinson St.

Garfield Forest Road

Garfield Forest Road

1-1-1907

1-1-1907

West Virginia

West Virginia

Shannon Forest

275 S. Robinson St.

Shannon Forest

Washington D. C.

1-1-1907

1-1-1907

1-1-1907

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04235

| | | | | | | | |
|---|---|--|--|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u> c. LENGTH OF STAY IN 1b
<u>1yr 11dys</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>SPRING GROVE STATE HOSPITAL</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE <u>Maryland</u> b. COUNTY <u>-</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> 3401-4
d. STREET ADDRESS
<u>2244 Brookfield Avenue</u>
a. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
<u>John</u> Middle
<u>Chester</u> Last
<u>Hamilton</u> | | 4. DATE OF DEATH
Month <u>April</u> Day
<u>20</u> Year
<u>1962</u> | | | | | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Nov. 20, 1881</u> | 9. AGE (In years last birthday)
<u>80</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>electrician</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u> </u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Virginia, -Petersburg</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S.</u> | |
| 13. FATHER'S NAME
<u>John Hamilton</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Fannie ?</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give year or dates of service)
<u>unknown</u> | | 16. SOCIAL SECURITY NO.
<u>unknown</u> | | 17. INFORMANT
Address
<u>Records: SPRING GROVE STATE HOSPITAL</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u>
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>
(a), stating the underlying cause last. DUE TO <u>GENERALIZED ARTERIOSCLEROSIS</u>
(c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | | | | | | | |
| 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>April 9, 1961</u> , to <u>April 20, 1962</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 20, 1962</u> , and that death occurred at <u>9:30</u> a.m., from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Loretta Y. F. Hsu</u> M.D. | | | | 22b. DATE SIGNED
<u>4-20-62</u> | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>LORETTA Y. F. HSU</u> | | | | 22d. ADDRESS
<u>SPRING GROVE STATE HOSPITAL</u>
<u>Catonsville 28, Maryland</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>4-23-62</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>St. Peters Cemetery</u> | | | |
| 23d. LOCATION (City, town or county) (State)
<u>Baltimore</u> <u>Maryland</u> | | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
<u>APR 23 '62</u> <u>Arthur S. Hines</u> | | | | | |

VR A15 (4)
15M 9/60

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04532

04532

M

INTERNAL 2ED ARTERIO-SCLEROSIS
ARTERIO-SCLEROTIC HEART DISEASE
MYOCARDIAL INFARCTION

W. H. H. H.

DOCTOR W. H. H. H.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04239

CERTIFICATE OF DEATH

04236

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>
c. LENGTH OF STAY IN b. <u>1</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8011 Temple Avenue</u> | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>
d. STREET ADDRESS <u>8011 Temple Avenue</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Asa Harrow Hamrick</u>
First Middle Last
5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>Nov 7, 1880</u>
9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired R.R. workern</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>West Virginia</u>
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Thomas Hamrick</u>
14. MOTHER'S MAIDEN NAME <u>Jane Baughman</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT <u>Mrs. Ella Hamrick</u> Address <u>8011 Temple Ave. #14</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary of Myocard</u>
DUE TO (b) <u>194 X</u>
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>194 X</u>
DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 1961</u> to <u>April 1962</u> , that (I) (we) last saw the deceased alive on <u>April 18, 1962</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>S. Elliott Harris</u> M.D. | | 22b. DATE SIGNED <u>4/20/62</u>
22c. PHYSICIAN'S NAME (Type) <u>S. Elliott Harris, M.D.</u>
22d. ADDRESS <u>9100 Harford Rd., Balto. 34 Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>4/23/62</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cem.</u> | 23d. LOCATION (City, town or county) (State) <u>Cowen, West Virginia</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck Inc.</u> ADDRESS <u>5305 Harford Road.</u> | | 25a. REC'D BY REGISTRAR <u>APR 24 '62</u> | 25b. REGISTRAR'S SIGNATURE <u>Christina L. Harris</u> |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|--|---|--|---|---|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | |
| 04240 | | | | | 04237 | | | | | |
| Item 14 FilmG312 5/8/62 iwk | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY - | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Fort Howard | | | c. LENGTH OF STAY IN lb
34 Days | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Baltimore | | | 3V01-4 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Veterans Administration Hospital | | | | | d. STREET ADDRESS
345 East Twenty-second Street | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print)
First GEORGE Middle -- Last HANDY | | | | | 4. DATE OF DEATH
Month April Day 29 Year 1962 | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
10-29-91 | | 9. AGE (In years last birthday) yrs. 70 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machinist | | | 10b. KIND OF BUSINESS OR INDUSTRY
Refractory | | | 11. BIRTHPLACE (County & State, or foreign country)
Talbot County, Maryland | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Charles Handy | | | | | 14. MOTHER'S MAIDEN NAME
unknown | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
Yes WW-1 | | | 16. SOCIAL SECURITY NO.
218-10-6628 | | 17. INFORMANT
Clin Rec VAH Fort Howard Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA
493X DOCKX
ARTERIOSCLEROTIC HEART DISEASE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
UNKNOWN
UNKNOWN | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour a.m. Month, Day, Year
p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 26, 1962 to April 29, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 29, 1962 , and that death occurred at 7:05 p.m. from the causes and on the date stated above. | | | | | | | | | | |
| 22a. SIGNATURE
Sebastian Russo | | | | | M.D.
SEBASTIAN RUSSO, M. D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
4-30-62 | |
| 22c. PHYSICIAN'S NAME (Type)
SEBASTIAN RUSSO, M. D. | | | | | 22d. ADDRESS
VAH, Fort Howard, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-4-62 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National | | | 23d. LOCATION (City, town or county) (State)
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Adolphus Talbot, 918 Druid Hill Ave. Baltimore, Md. | | | | | 25a. REC'D BY REGISTRAR
MAY 1 '62 | | 25b. REGISTRAR'S SIGNATURE
Arthur J. Krasner | | | |

M

12240

02250

Maryland

Baltimore

Baltimore

34 Days

Fort Howard

Veterans Administration Hospital

345 East Twenty-second Street

OPWOS

--

HANDY

April

22

22

70

10-22-91

1

1919

Male

Refugeary

Refugeary

Talbot County, Maryland

U.S.A.

Charles Handy

218-10-6023 Clin Rec VAM Fort Howard Maryland

Yes

X

March 22, 1905

April 22

April 22

11-30-02

VAM, Fort Howard, Maryland

Baltimore, Maryland

Baltimore National

Baltimore

Handwritten signature

1
FOR STATE
HEALTH DEPT.

Division of
04241

FORENSIC MEDICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04238

| | | | | | |
|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
e. STATE
Maryland | | b. COUNTY
Baltimore | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Mt. Washington | | c. LENGTH OF STAY IN b.
1 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Mt. Washington | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
1204 Fairfield Avenue | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
WILLIAM EARLE HARRIS | | First Middle Last
WILLIAM EARLE HARRIS | | 4. DATE OF DEATH
Month Day Year
April 16 1962 | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
March 6, 1896 | | 9. AGE (In years last birthday)
66 yrs. | | 10. IF UNDER 1 YEAR
Months Days
66 | |
| 11. IF UNDER 24 HRS.
Hours Min.
66 | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Automobile Mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY
Maryland | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
William T. Harris | | 14. MOTHER'S MAIDEN NAME
Delia Lawrence | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
213 01 2129 | | 17. INFORMANT
Address
Harold J. MacMillan, 1314 Appleby Ave., Balto. 9 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
148X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
Asphyxia from massive hemorrhage of Carcinoma of throat
DUE TO (c)
Sudden | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Asphyxia from massive hemorrhage of Carcinoma of throat | | INTERVAL BETWEEN ONSET AND DEATH
Sudden | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21c. TIME OF INJURY
Hour a.m. p.m.
19 | | 21d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 21f. (City or town)
Baltimore | | 21g. (County)
Baltimore | | 21h. (State)
Maryland | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from
Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Charles F. O'Donnell
Address (Street, city, town, or county)
Baltimore Co., Maryland | | DATE SIGNED
4/16/62 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
April 19, 1962 | | 22c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cem. | |
| 22d. LOCATION (City, town, or country)
Baltimore, Maryland | | 22e. REC'D BY REGISTRAR
APR 18 '62 | | 22f. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |
| 23. FUNERAL DIRECTOR
Burgee Funeral Home | | 23a. ADDRESS
3631 Falls Rd Balto. Md. | | 23b. BY
Noelce K. Burgee | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04239

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTO.</u> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>115 BEAUMONT AVE</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>
d. STREET ADDRESS <u>115 BEAUMONT AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ALICE MOULTON HAYNES</u> | | | | 4. DATE OF DEATH Month Day Year <u>April 24 19 62</u> | | | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>AUG. 18, 1877</u> | | | |
| 9. AGE (In years last birthday) <u>84</u> yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | | | | | |
| 13. FATHER'S NAME <u>William S. Moulton</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Isabelle Callio</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mrs Isabelle Hasher</u> Address <u>115 Beaumont Ave</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u>
170X DUE TO (b) <u>Carcinoma of Breast</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 yr.</u>
<u>5 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 9 1952</u> to <u>April 24 1962</u> that (I) (we) last saw the deceased alive on <u>April 24 1962</u> and that death occurred at <u>4:45 P.</u> from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>James R. Grabill</u> | | | | 22b. ADDRESS <u>5550 Balto Nat'l Pike</u> | | 22c. PHYSICIAN'S NAME (Type) <u>James R. GRABILL, M.D.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 23b. DATE THEREOF <u>4-27-62</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cem.</u> | | | |
| 23d. LOCATION (City, town or county) <u>Balto.</u> | | | | 23e. REGISTRAR'S SIGNATURE <u>Charles E. Hanes</u> | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Foley Funeral Home - Catonsville, Md.</u> | | | | 25. REC'D BY REGISTRAR <u>APR 30 62</u> | | 25b. REGISTRAR'S SIGNATURE | | | |

MEDICAL CERTIFICATION

TO HOSPITAL (If attending physician is retained by the hospital or attending physician, page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

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[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "General", "Department", and "Office" are faintly visible.]

TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04243

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04240

| | | | | | |
|---|----------------------------------|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Catonsville | | | c. LENGTH OF STAY IN lb
7mth 15days | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Elkridge, Maryland | | |
| d. STREET ADDRESS
4950 Tulip Avenue | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print)
First Leonard Middle L. B. Last Heron | | | 4. DATE OF DEATH
Month April Day 24 , Year 1962 | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 11, 1882 | 9. AGE (In years last birthday)
79 yrs. | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
printer | | | 10b. KIND OF BUSINESS OR INDUSTRY
Retired | | |
| 11. BIRTHPLACE (County & State, or foreign country)
Scotland | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | | |
| 13. FATHER'S NAME
unknown John Heron | | | 14. MOTHER'S MAIDEN NAME
Mary Scott | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
unknown | | | 16. SOCIAL SECURITY NO.
unknown | | |
| 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
537X DUE TO (b) Abscess of Parotid gland (left)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chronic Brain Syndrome assoc with Cerebr. Arteriosclerosis | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | 20g. (County) | | 20h. (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Aug. 21, 1961 to April 24, 1962 that (I) (we) last saw the deceased alive on April 24 - 1962 , and that death occurred at 7:05 PM from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
Jose R. Arizaga M.D. | | | 22b. DATE SIGNED | | |
| 22c. PHYSICIAN'S NAME (Type)
JOSE R. ARIZAGA, M.D. | | | 22d. ADDRESS
SPRING GROVE STATE HOSPITAL
Catonsville 28, Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/27/62 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Cemetery | |
| 23d. LOCATION (City, town or county) | | 23e. (State)
Elkridge, Howard Co., Md. | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
XXXXXX Howard H. Hubbard | | | 25a. REC'D BY REGISTRAR
APR 27 '62 | | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Harris | | | DATE | | |

13
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04244 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04241

| | | | | | | | |
|---|--|------------------------------------|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Md. b. COUNTY Balto. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Reisterstown | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Reisterstown | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Cherry Hill Lane & Reisterstown Rd. | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
Benjamin H. Higgs Sr. | | | | 4. DATE OF DEATH
April 27, 1962 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Jan. 24, 1894 | |
| 9. AGE (In years last birthday)
68 yrs. | | 10. IF UNDER 1 YEAR
Months Days | | 11. IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country)
Virginia | | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 13. FATHER'S NAME
Jacob T. Higgs | | | | 14. MOTHER'S MAIDEN NAME
Barbara L. Painter | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | | | 16. SOCIAL SECURITY NO.
217-12-3167 | | | |
| 17. INFORMANT
Mr. Benjamin H. Higgs Jr. | | | | Address
Owings Mills, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
none | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH
5 min.? | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. none | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
none | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. none 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> none | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
none | | | | 20f. (City or town) (County) (State)
none | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE D. D. Caples | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) D. D. Caples, M. D. | | | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DATE SIGNED 4-28-62 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 22b. DATE THEREOF
April 30, 1962 | | | |
| 22c. NAME OF CEMETERY OR CREMATORY
Good Shephard | | | | 22d. LOCATION (City, town, or country) (State)
Ellicott City Md. | | | |
| 23. FUNERAL DIRECTOR
J. F. Eline & Sons | | | | ADDRESS
Reisterstown, Md. | | | |
| 24a. REC'D BY REGISTRAR
MAY 1 '62 | | | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Kraus | | | |

FOR THE
DEATH CERTIFICATE

(M)

(1)

Baltimore

Baltimore

George Hill Lane & Baltimore, Md.

Bookkeeping and

Baltimore

Highway

Male

White

Jan. 24, 1894

Barber

Virginia

James T. Hines

Barber J. Palmer

No

21-10-2407

No

Y. County, Maryland

Swineville, Md.

None

None

None

None

None

None

None

None

Good Shepherd

St. Joseph's

St. Joseph's

St. Joseph's

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04245
CERTIFICATE OF DEATH
04242

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Dundalk | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Dundalk | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
6917 Ridgeway | | d. STREET ADDRESS
6917 Ridgeway | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) ARTHUR D. HILL | | 4. DATE OF DEATH
April 30, 1962 19 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 20, 1884 |
| 9. AGE (In years last birthday) 77 yrs. | | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Watchman-ret. | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
St. Louis, Missouri | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Byron F. Hill | | 14. MOTHER'S MAIDEN NAME
Elizabeth Estes | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Arthur J. Alfeld 6917 Ridgeway | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary Thrombosis
420.1 DUE TO Arterio Sclerotic C.V. Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Apr 26, 1962 to Apr 30, 1962 , that (I) (we) last saw the deceased alive on Apr 26, 1962 , and that death occurred at 1 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Stephen A. Mackowick | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) STEPHEN A. MACKOWICK | | 22d. ADDRESS
6714 Holobird Ave Baltimore Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
May 1, 1962 | |
| 23c. NAME OF CEMETERY OR CREMATORY
St. Matthew's Cemetery | | 23d. LOCATION (City, town or county) (State)
St. Louis, Missouri | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Ulrich Funeral Home Dundalk, Md. | | 25a. REC'D BY REGISTRAR
DATE MAY 3 '62 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

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04515

STATE OF TEXAS

County of ...

City of ...

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 34 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 04246 | | | | | 04243 | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) | | | | |
| a. COUNTY <u>Baltimore</u> MARYLAND | | | | | e. STATE <u>MD.</u> b. COUNTY <u>✓</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Cockeysville</u> | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | | | |
| c. LENGTH OF STAY IN 1b <u>8 yrs.</u> | | | | | d. STREET ADDRESS <u>1835 Bolton St.</u> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MD. Masonic Home</u> | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Mary Holland</u> | | | | | 4. DATE OF DEATH <u>April 22 1962</u> | | | | |
| 5. SEX <u>Female</u> | | | | | 6. COLOR OR RACE <u>White</u> | | | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 8. DATE OF BIRTH <u>Sept 18, 1881</u> | | | | |
| 9. AGE (In years last birthday) <u>80</u> yrs. | | | | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | | | | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u> | | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | |
| 13. FATHER'S NAME <u>James C Pringle</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Morris</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service) | | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | | | |
| 17. INFORMANT <u>MD Masonic Home - Cockeysville</u> | | | | | Address | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis - byx hemiplegia</u>
4221 DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Cardiovascular disease</u>
(c) <u>4221</u>
DUE TO
(a) stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u> | | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April 21 1962</u> to <u>April 22 1962</u> ; that (I) (we) last saw the deceased alive on <u>April 21 1962</u> , and that death occurred at <u>7:20 PM</u> , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>Elizabeth B. Shorrell</u> M.D. | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Elizabeth B. Shorrell MD</u> | | | | | 22b. DATE SIGNED <u>4/22/62</u> | | | | |
| 22d. ADDRESS <u>Cockeysville, Md.</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | | 23b. DATE THEREOF <u>4-25-62</u> | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u> | | | | | 23d. LOCATION (City, town or county) (State) <u>Woodlawn, Maryland</u> | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street, Baltimore 2</u> | | | | | 25a. REC'D BY REGISTRAR <u>APR 24 '62</u> | | | | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u> | | | | | | | | | |

(M)

0248

02513

James C. Thompson
1111 St. Paul Street, Baltimore 2

May 11, 1941

Dear Sir:

Enclosed for you are
two copies of the

report of the

investigation of the

case of the

murder of the

President of the

United States

Very truly yours,

John Edgar Hoover
Director

Enclosure 2
Baltimore 2

U.S. Dept. of Justice
1111 St. Paul Street, Baltimore 2

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(4)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04247 CERTIFICATE OF DEATH 04244

| | | | |
|--|-------------------------------|--|------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore Co.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Catonsville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wright Care Nursing Home</u> | | d. STREET ADDRESS <u>3411 Rolling Road</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Blanche R. Hook</u> | | 4. DATE OF DEATH Month Day Year <u>April 21, 1962 19</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1879</u> |
| 9. AGE (In years last birthday) <u>82</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Address <u>Mrs. Blanche East-418 Stratford Rd.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE</u>
422-1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BRONCHITIS - PNEUMONITIS</u>
DUE TO
(c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/1</u> , 19 <u>62</u> to <u>4/21</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>4/21</u> , 19 <u>62</u> , and that death occurred at <u>6:00</u> M., from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>John H. Shaw</u> M.D. | | 22b. DATE SIGNED <u>4/23/62</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>John H. Shaw</u> | | 22d. ADDRESS <u>6844 Edmonson Ave. NW - 28 - NW</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>4/25/62</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Edgewood Armacost</u> ADDRESS <u>Ellsworth Armacost-4600 Liberty Hgts. Avenue</u> | | 25a. REC'D BY REGISTRAR DATE <u>APR 25 '62</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u> | |

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---------------------------|--|---|--|--|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 04248 | | | | | | | | | | | |
| Items 1c & 4 Film 311 4/24/62 mh | | | | | | | | | | | |
| 04245 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
Baltimore | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
e. STATE
Maryland | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Catonsville | | | | c. LENGTH OF STAY IN 1b
7 days | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Baltimore | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | | | d. STREET ADDRESS
405 East Fort Avenue | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
George Allen Hook | | | | 4. DATE OF DEATH
April 12, 1962 | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 5. SEX
male | | 6. COLOR OR RACE
white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Dec. 14, 1886 | | 9. AGE (In years last birthday)
75 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
unknown | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Maryland | | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | | | |
| 13. FATHER'S NAME
George Hook | | | | 14. MOTHER'S MAIDEN NAME
Katherine | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
unknown | | | | 16. SOCIAL SECURITY NO.
unknown | | | | 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Failure
422.1 DUE TO (b) Atherosclerotic Cardiovascular
Disease
DUE TO (c) Disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
Hours
Years | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
(County)
(State) | | | |
| 21. I certify that (X) (this hospital) attended the deceased from April 5, 1962 to April 12, 1962, that (I) (we) last saw the deceased alive on April 12, 1962, and that death occurred at 5:50 PM from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Jose F. Cruzaga, M.D. | | | | 22b. DATE SIGNED | | | | 22c. PHYSICIAN'S NAME (Type)
SPRING GROVE STATE HOSP. | | | |
| 22d. ADDRESS
SPRING GROVE STATE HOSPITAL
Catonsville 28, Md. | | | | 22e. REC'D BY REGISTRAR
DATE APR 16 '62 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE THEREOF
4-16-62 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | | 23d. LOCATION (City, town or county)
Balto 25 MD. | | 23e. REGISTRAR'S SIGNATURE
Arthur L. Hines | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
My Cully | | | | 24b. ADDRESS
130 S Fort Ave | | | | 24c. DATE
APR 16 '62 | | | |

6513

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Division of
Fish and Wildlife
Bureau

Division of
Fish and Wildlife
Bureau

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04249

04246

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Carroll ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. LENGTH OF STAY IN Ib
3 Hours 45 min. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Veterans Administration Hospital | | d. STREET ADDRESS
Box 123 RFD 4 | |
| 3. NAME OF DECEASED
Served as: DAVID W. HOOPER
(Type or print) | | 4. DATE OF DEATH
Month April Day 27 Year 1962 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
October 16, 1887 |
| 9. AGE (In years last birthday)
74 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farm Hand | |
| 11. BIRTHPLACE (County & State, or foreign country)
Carroll County, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Reese Hooper | | 14. MOTHER'S MAIDEN NAME
Alice Haines | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)
Yes WW-1 | | 16. SOCIAL SECURITY NO.
215-18-1423 | |
| 17. INFORMANT
Clinical Records, VA Hospital, Fort Howard, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY THROMBOSIS
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Peritonitis secondary to Appendiceal Abscess. Pneumonia. | | INTERVAL BETWEEN ONSET AND DEATH
1 1/2 Hour | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that N (this hospital) attended the deceased from April 27, 1962 to April 27, 1962 , that (X) (we) last saw the deceased alive on April 27, 1962 , and that death occurred 4:45 from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
[Signature] | | 22b. DATE SIGNED
4/28/62 | |
| 22c. PHYSICIAN'S NAME (Type)
JOSHUA SMITH, M.D. | | 22d. ADDRESS
VA Hospital, Fort Howard, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/1/62 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Bethany Cemetery | | 23d. LOCATION (City, town or county) (State)
Faylarsville Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
J. E. Myers, Jr. | | 25a. REC'D BY REGISTRAR
MAY 1 '62 | |
| ADDRESS
Westminster, Md. | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Hines | |

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CERTIFICATE OF DEATH

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04250

CERTIFICATE OF DEATH

04247

Item 4 Film G313 5/18/62 jvk

| | | | |
|---|------------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)
a. STATE Maryland b. COUNTY - | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. LENGTH OF STAY IN lb
5 Days | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Veterans Administration Hospital | | d. STREET ADDRESS
612 W. LaFayette Avenue | |
| 3. NAME OF DECEASED
(Type or print)
THOMAS P. HOWARD | | 4. DATE OF DEATH
Month 22 Day 17TH Year 1962 | |
| 5. SEX
Male | 6. COLOR OR RACE
Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7/2/25 |
| 9. AGE (In years last birthday)
36 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY
Construction | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Ernest Howard | | 14. MOTHER'S MAIDEN NAME
Mary Griggs | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
Yes WW II | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Clin. Rec. VAH, Fort Howard, Maryland | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) UREMIA
DUE TO
441X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) HYPERTENSIVE CARDIOVASCULAR DISEASE (MALIGNANT NEPHROSCLEROSIS)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (this hospital) attended the deceased from 4/17/1962 to 4/22/1962 , that (I) (we) last saw the deceased alive on 4/22/1962 , and that death occurred at 4:30 AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Joshua D. Smith M.D. | | 22b. DATE SIGNED
4/22/62 | |
| 22c. PHYSICIAN'S NAME (Type)
JOSHUA SMITH, M.D. | | 22d. ADDRESS
VA HOSPITAL, FORT HOWARD, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/26/62 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National | | 23d. LOCATION (City, town or county) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Elroy O. Wilson | | 25a. REC'D BY REGISTRAR
DATE APR 27 '62 | |
| ADDRESS
1000 Brantley Ave. Baltimore 17, Maryland | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
15M 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04251

04248

| | | | | | | | |
|--|----------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY - | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Perry Hall | | c. LENGTH OF STAY IN lb | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Baltimore | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Box # 150 Forge Rd. | | | | d. STREET ADDRESS
332 Folcroft St. # 24 | | | |
| 3. NAME OF DECEASED
(Type or print)
GERTRUDE | | First Middle Last
BARBARA | | 4. DATE OF DEATH
April 30 | | Year
19 62. | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 28, 1910 | | 9. AGE (In years last birthday)
51 yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House Work | | 10b. KIND OF BUSINESS OR INDUSTRY
At Home. | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Casper Fischer | | | | 14. MOTHER'S MAIDEN NAME
Margaret Lindenberger | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
----- | | 17. INFORMANT
John Louis Huber | | Address
Same. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of gall bladder
155.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)
(c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
6 mos |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Febr 14, 1962 to April 30, 1962 that (I) (we) last saw the deceased alive on April 30, 1962 and that death occurred at 6:25 P.M. EDT from the cause and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Theodore E. Evans | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
5/2/62 | |
| 22c. PHYSICIAN'S NAME (Type)
Theodore E. Evans, M. D. | | | | 22d. ADDRESS
9660 Belair Rd. Balto 36, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5- 3 -62. | | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart Cemetery | | 23d. LOCATION (City, town or county) (State)
7501 German Hill Rd., Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Charles S. Galer | | | | ADDRESS
6224 Eastern Ave. Balto., Md. | | 25a. REC'D BY REGISTRAR
DATE MAY 3 '62 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Evans | | | |

10301

01218

(M)

Baltimore

Perry Hill

Box 4 150 Perry Hill

Baltimore

325 Lafayette St. & 24

1841/002

1841/002

1841/002

1841/002

Female

White

Nov. 22, 1919

House work

at home

Baltimore, Md.

Chaper. Teacher

Chaper. Teacher

John Louis Miller

Same

Chaper. Teacher

Same

Small B

Small B

Small B

Small B

Small B

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01249

| | | | |
|---|----------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u> ✓
<u>345 WHITRIDGE AVE.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CATONSVILLE</u> | | c. LENGTH OF STAY IN 1b
<u>BALTO.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>SUMMIT NURS. HOME.</u> | | d. STREET ADDRESS
<u>345 WHITRIDGE RD.</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>CATHERINE</u> Middle <u>HUDSON</u> Last <u>HUDSON</u> | | 4. DATE OF DEATH
Month <u>APR.</u> Day <u>4</u> Year <u>1962</u> | |
| 5. SEX <u>F.</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>MAY 15, 1883</u> |
| 9. AGE (In years last birthday) <u>78</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months _____ Days _____ Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>H.W.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>D.H.</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>IRELAND.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>HURLEY</u> | | 14. MOTHER'S MAIDEN NAME
<u>UNKNOWN</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>MR. WILLIAM H. HUDSON (SON)</u>
<u>1226 CEDARCROFT RD., BALTO. 12, MD.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia, lobar,</u>
<u>420.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis/Heart Disease.</u>
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis. CERVICAL POLYS-REMOVED 28 MAR 1962.</u>
INTERVAL BETWEEN ONSET AND DEATH
<u>3 days</u>
<u>5 + yrs.</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>1962.</u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>27 March 1962</u> to <u>4 April</u> , 19 <u>62</u> that I last saw the deceased alive on <u>4 April</u> , 19 <u>62</u> , and that death occurred at <u>1:35 P.M.</u> from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>6348 FREDERICK RD BALTO. MD.</u> DATE SIGNED <u>4 Apr 1962</u>
ACTUAL SIGNATURE <u>John N. Snyder</u> M.D.
PHYSICIAN'S NAME (Type) <u>JOHN N. SNYDER M.D. BALTIMORE 28, MD.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>RURAL</u> | | 22b. DATE THEREOF
<u>4/7/62</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>NEW CATHEDRAL</u> | | 22d. LOCATION (City, town, or county) (State)
<u>BALTO. MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>WITZKE, 4101 EDMONDSON AVE.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>APR 6 1962</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Charles E. Hanna</u> | | | |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04253

04250

| | | | |
|---|---------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTO. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODLAWN | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - WOODLAWN | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION DOGWOOD RD - BOT 1961 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last CHARLES HENRY HUMPHREY | | 4. DATE OF DEATH Month Day Year 4 29 19 62 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JULY 7, 1873 |
| 9. AGE (In years last birthday) 88 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GARDENER | | 10b. KIND OF BUSINESS OR INDUSTRY GARDENER | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOHN HUMPHREY | | 14. MOTHER'S MAIDEN NAME — | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 216-07-4010 | |
| 17. INFORMANT MR. LUTHER HUMPHREY - DOGWOOD RD - BALTO. 7, MD. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) DEGENERATIVE HEART DISEASE
443X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE C.V. DISEASE
(c) — | | INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from JUNE 5, 19 50 to APRIL 29, 19 62 that (I) (was) lost saw the deceased alive on APRIL 24, 19 62 , and that death occurred at 6:30 P. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Edwin L. Pierpont | | 22b. DATE SIGNED 4/29/62 | |
| 22c. PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT, M.D. | | 22d. ADDRESS 8704 LIBERTY RD - BALTO. 7, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 5-2-62 | |
| 23c. NAME OF CEMETERY OR CREMATORY Good Shepherd | | 23d. LOCATION (City, town, or county) (State) Ellicott City, Md | |
| 24. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md | | 25a. REC'D BY REGISTRAR MAY 1 '62 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Krause | | DATE | |

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F. C. Hildner & Co., Ltd.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04251

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <i>Baltimore</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
e. STATE <i>Md.</i> b. COUNTY <i>-</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Parkville</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Parkville - Baltimore</i> | |
| c. LENGTH OF STAY IN <i>1b</i> | | d. STREET ADDRESS <i>2805 Westfield Ave.</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<i>7814 Elmhurst Ave.</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <i>Isabella M.</i> Middle <i>Hupfeld</i> Last <i>-7814-Elmhurst Ave.</i> | | 4. DATE OF DEATH
Month <i>4</i> Day <i>19</i> Year <i>62</i> | |
| 5. SEX
<i>female</i> | 6. COLOR OR RACE
<i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>Sept 9, 1881</i> |
| 9. AGE (In years last birthday)
<i>80</i> | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<i>Washington, D.C.</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 13. FATHER'S NAME
<i>Gustaf Giesecke</i> | | 14. MOTHER'S MAIDEN NAME
<i>Lena Seebode</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) | | 16. SOCIAL SECURITY NO.
<i>220-30-1404 B.</i> | |
| 17. INFORMANT
<i>Mrs. Henry C. Hupfeld</i> | | Address <i>same.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardio Renal Vascular disease</i>
DUE TO (b) <i>442X</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH
<i>8 wks</i> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a.m. <i>19</i> p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>1958</i> to <i>ap. 19, 1962</i> , that (I) (we) last saw the deceased alive on <i>ap. 17, 1962</i> , and that death occurred at <i>5 P.M.</i> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Harold H. Burns</i> | | 22b. DATE SIGNED
<i>ap 19-62</i> | |
| 22c. PHYSICIAN'S NAME (Type)
<i>Harold H. Burns</i> | | 22d. ADDRESS
<i>8106 Harford Rd. Maryland</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE THEREOF
<i>4/23/62</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<i>Cedar Hill Cemetery</i> | | 23d. LOCATION (City, town or county) (State)
<i>Baltimore, Maryland</i> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>L. J. Ruck Inc.</i> | | 25a. REC'D BY REGISTRAR
<i>APR 24 '62</i> | |
| ADDRESS
<i>5305 Harford Rd.</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Arthur L. House</i> | |

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Vol. 12510

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04252

| | | | |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Dorchester | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN lb 24 Days | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital | | e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge | |
| f. STREET ADDRESS 11 Cemetery Ave | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) WILLIAM Leroy HURLOCK | | 4. DATE OF DEATH April 19 19 62 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH September 9, 1915 |
| 9. AGE (In years last birthday) 46 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | | 10b. KIND OF BUSINESS OR INDUSTRY Self employed | |
| 11. BIRTHPLACE (County & State, or foreign country) Preston, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William Hurlock | | 14. MOTHER'S MAIDEN NAME Ida F. Blades | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II | | 16. SOCIAL SECURITY NO. 218-03-5903 | |
| 17. INFORMANT Clinical Records Veterans Adm. Hosp. Ft Howard, Md | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SQUAMOUS CELL CARCINOMA RIGHT LUNG WITH METASTASES
TO THORACIC WALL AND DIAPHRAGM
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PNEUMONIA, BILATERAL
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
4 days | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year 19
Hour e.m. p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 26, 1962 to April 19, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 19, 1962 , and that death occurred at 6:45 P M, from the causes and on the date stated above. | | 22a. SIGNATURE Sebastian Russo M.D. | |
| 22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D. | | 22b. DATE SIGNED 4/20/62 | |
| 22d. ADDRESS VAH FT HOWARD, MD | | 22e. REC'D BY REGISTRAR APR 23 '62 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF April 23, 1962 | |
| 23c. NAME OF CEMETERY OR CREMATORY Washington Cemetery | | 23d. LOCATION (City, town or county) (State) Hurlock, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE J.J. Framptom and Son, Federalsburg, Maryland | | 25a. REGISTRAR'S SIGNATURE Arthur S. Kline | |

04325

04325



Handwritten signature or initials

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04253

| | | | | | | | |
|---|----------------------------------|---|------------------------------------|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Carroll | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Owings Mills | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Taneytown | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Rosewood State Training School | | | | d. STREET ADDRESS
Route 2 | | | |
| 3. NAME OF DECEASED
(Type or print)
Michael Eugene HYSER | | | | 4. DATE OF DEATH
Month April Day 20 Year 19 62 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8/12/61 | | 9. AGE (in years last birthday)
8 yrs. | | IF UNDER 1 YEAR
Months 8 Days 8 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
dependent | | | | 10b. KIND OF BUSINESS OR INDUSTRY
none | | 11. BIRTHPLACE (County & State, or foreign country)
Gettysburg, Pennsylvania | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 13. FATHER'S NAME
Fred Leroy Hyser | | | |
| 14. MOTHER'S MAIDEN NAME
Betty Fogle (Hyser) | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | | |
| 16. SOCIAL SECURITY NO.
none | | | | 17. INFORMANT
Rosewood Records, Owings Mills, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) aspiration pneumonia
752x DUE TO
Conditions, if any, which gave rise to immediate cause (b) Inhalation of food
(c) Hydrocephalic condition
DUE TO
cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Hydrocephalus communicating type (Birth) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Two days
Two days | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour e.m. 19
p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 17 April, 1962 to 20 April 1962 , that (I) (we) last saw the deceased alive on 20 April 1962 , and that death occurred at 20 April 1962 M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Harry G. Butler M.D. | | | | 22b. DATE SIGNED
20 April 62 | | | |
| 22c. PHYSICIAN'S NAME (Type)
Harry G. Butler | | | | 22d. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
April 22, 1962 | | 23c. NAME OF CEMETERY OR CREMATORY
Piney Creek Presbyterian Cem. | | 23d. LOCATION (City, town or county) (State)
Taneytown, Carroll, Md. | |
| 24. FUNERAL DIRECTOR'S NAME (Type)
Ed. Fuss Hon | | | | 25a. REC'D BY REGISTRAR
APR 23 '62 | | 25b. REGISTRAR'S SIGNATURE
John S. Hanes | |

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04254

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard
c. LENGTH OF STAY IN lb
11 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Veterans Administration Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
-
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 2
d. STREET ADDRESS
716 Aisquith St.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Charles
First
--
Middle
Ingram
Last | | 4. DATE OF DEATH
April
Month
27
Day
19
Year
62 | |
| 5. SEX
Male | | 6. COLOR OR RACE
Negro | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
February 3, 1890
yrs. | |
| 9. AGE (In years last birthday)
72 | | 10. IF UNDER 1 YEAR
Months
Days
Hours
Min. | |
| 11. BIRTHPLACE (County & State, or foreign country)
Lunenburg Co., Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
James Anthony Ingram | | 14. MOTHER'S MAIDEN NAME
Hester Stokes | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
Yes WW I | | 16. SOCIAL SECURITY NO.
218-10-1846 | |
| 17. INFORMANT
Clinical Records, VAH, Fort Howard, Maryland
Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EDEMA
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ARTERIOSCLEROTIC HEART DISEASE
DUE TO
(c) DIABETES MELLITUS | | INTERVAL BETWEEN ONSET AND DEATH
RECENT
UNKNOWN
UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m.
p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 16, 1962 , to April 27, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 27, 1962 , and that death occurred at 9:30 AM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Thomas F. Crahan M.D. | | 22b. DATE
4/27/62 | |
| 22c. PHYSICIAN'S NAME (Type)
THOMAS F. CRAHAN, M.D. | | 22d. ADDRESS
VAH, Fort Howard, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
3-2-62 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National | | 23d. LOCATION (City, town or county) (State)
Baltimore 28, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
ELROY O. WILSON | | 25a. REC'D BY REGISTRAR
MAY 1 '62 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

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Reg. Dist. No. 14255

04258

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
BALTIMORE | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
MARYLAND | | b. COUNTY
BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rockdale | | c. LENGTH OF STAY IN 1b
1 WEEK | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | | 3401.4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
LIBERTY COURT REHABILITATION CENTER | | | | d. STREET ADDRESS
5417 LYNVIEW AVE | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) ESTHER | | First
ISEKOFF | | Middle
ISEKOFF | | Last
ISEKOFF | |
| 4. DATE OF DEATH
Month
APRIL | | Day
29 | | Year
1962 | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
MAY 5, 1899 | |
| 9. AGE (In years last birthday)
62 yrs. | | IF UNDER 1 YEAR
Months
62 | | IF UNDER 24 HRS.
Days
62 | | Hours
62 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSE WIFE | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
RUSSIA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
SAMUEL | | | | 14. MOTHER'S MAIDEN NAME
GERTRUDE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
MAX ISEKOFF | | INFORMANT
MAX ISEKOFF | | Address
SAME | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized carcinomatosis
199X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO
(c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. _____
p. m. _____
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from Jan 1962 to April 29, 1962 what I last saw the deceased alive on 4-28-1962 , and that death occurred at 2:45 P.M. from the causes and on the date stated above
ADDRESS (Street, city or town, state) 5401 Old Court Rd. Randallstown
DATE SIGNED _____
ACTUAL SIGNATURE Joseph Deckelbaum M.D.
PHYSICIAN'S NAME (Type) JOSEPH DECKELBAUM, M.D. Randallstown | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
5/1/1962 | | 22c. NAME OF CEMETERY OR CREMATORY
ROSEDALE | | 22d. LOCATION (City, town, or county) (State)
BALTO. MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Jack Lewis Inc | | | | ADDRESS
2100 Eutan Pl. | | 24a. REC'D BY REGISTRAR
DATE MAY 2 '62 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hines | | | |

CERTIFICATE OF DEATH

94330

1945

(M)

1. Name of deceased: *John J. [illegible]*
2. Sex: *Male*
3. Age: *45*
4. Date of death: *Jan 25 1945*
5. Place of death: *Home*
6. Cause of death: *Heart disease*
7. Signature of physician: *[illegible]*
8. Signature of registrar: *[illegible]*
9. Date of registration: *Jan 25 1945*

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 ~~may~~ be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04260

04257

| | | | | | | | |
|--|---|--|--|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Balto.</u> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>
c. LENGTH OF STAY IN <u>8 years</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1312 Jugwell Ave</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>Balto.</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>
d. STREET ADDRESS <u>1312 Jugwell Ave</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Edward L. Jacobs</u> | | 4. DATE OF DEATH
Month <u>April</u> Day <u>9</u> Year <u>1962</u> | | | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Oct. 2, 1887</u> | 9. AGE (In years last birthday) <u>74</u> yrs.
IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) <u>Clerk</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Gas & Elec. Md</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>USA</u> | | | |
| 13. FATHER'S NAME
<u>Charles E. Jacobs</u> | | 14. MOTHER'S MAIDEN NAME
<u>Amelia Hoffman</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> | | 16. SOCIAL SECURITY NO. <u>213-03-8704</u> | | 17. INFORMANT
<u>Mrs. Elsie Jacobs (same)</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u>
<u>527.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>Cor Pulmonale</u>
(a), stating the underlying cause last. DUE TO (c) <u>Emphysema</u> | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>36 hrs</u>
<u>3 yrs.</u>
<u>undet.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u> </u> e.m. <u> </u> 19 <u> </u>
p.m. <u> </u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April 3, 1962</u> to <u>April 9, 1962</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>April 7, 1962</u> , and that death occurred at <u>11A</u> M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Bradley Dougherty</u> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>4-10-62</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>4/12/62</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Western</u> | 23d. LOCATION (City, town or county) (State) <u>Balto. Md</u> | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Witke F. H. 4101 Edmondson</u> | | ADDRESS <u> </u> | | 25a. REC'D BY REGISTRAR
DATE <u>APR 12 '62</u> | 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. ...</u> | | |

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0125

(M)

(1)

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "C. in the" and "C. in the" are faintly visible.]

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 236, Film G313 5/16/62 iwk

04258

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)
a. STATE Maryland b. COUNTY - | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Fort Howard | | | | c. LENGTH OF STAY IN lb
13 Days | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Veterans Administration Hospital | | | | d. STREET ADDRESS
1409 E. Lafayette Avenue | | | |
| 3. NAME OF DECEASED
(Type or print)
First FLETCHER Middle (NMI) Last JACOBS | | | | 4. DATE OF DEATH
Month APRIL Day 9 Year 19 62 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Colored | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
11/27/05 | |
| 9. AGE (In years last birthday)
56 yrs. | | IF UNDER 1 YEAR
Months 0 Days 0 | | IF UNDER 24 HRS.
Hours 0 Min. 0 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Janitor | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Rubber Tire Co. | | 11. BIRTHPLACE (County & State, or foreign country)
Live Oak, Florida | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
Robert Jacobs | | | | 14. MOTHER'S MAIDEN NAME
Cora Bush | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
Yes WW II | | | | 16. SOCIAL SECURITY NO.
719-10-0077 | | 17. INFORMANT
Clin. Rec. VAH, Fort Howard, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDITIS
422.2 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypostatic Bronchopneumonia, right; Pheochromocytoma left adrenal | | | | INTERVAL BETWEEN ONSET AND DEATH
Unk | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (1) (this hospital) attended the deceased from 3/27 4:15 PM to 4/9/ , 19 62 , that (1) (we) last saw the deceased alive on 4/9/ , 19 62 , and that death occurred 4/9/ , 19 62 , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Sebastian Russo M.D. | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
4/10/62 | |
| 22c. PHYSICIAN'S NAME (Type)
SEBASTIAN RUSSO, M.D. | | | | 22d. ADDRESS
VA HOSPITAL, FORT HOWARD, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/13/62 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National | | 23d. LOCATION (City, town or county) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Elliott Funeral Home | | | | ADDRESS
1129 N. Caroline St. Baltimore, Maryland | | 25a. REC'D BY REGISTRAR
APR 11 '62 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Thomas | | | |

RECEIVED

OSCAR NIEMEYER

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04259

04256

| | | | | | | | |
|--|------------------------------|---|---|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MD. b. COUNTY BALTO. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CATONSVILLE | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CATONSVILLE | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
9 BEACHWOOD AVE | | | | e. STREET ADDRESS
9 BEACHWOOD AVE | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
ANNIE VIRGINIA JOBSON | | | | 4. DATE OF DEATH
Month Day Year
APRIL 17 1962 | | | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
JAN. 26 1870 | 9. AGE (in years last birthday)
92 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEKEEPER | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Home | | 11. BIRTHPLACE (County & State, or foreign country)
PENN. | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | | | |
| 13. FATHER'S NAME
George E. Earley | | | | 14. MOTHER'S MAIDEN NAME
Mary Rittner | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT
George B. Johnson - 9 Beachwood Ave | | | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Brain - Pneumonia | | | | | | 36 hrs | |
| DUE TO (b) Cerebral Palsy - Severe | | | | | | 4 mos | |
| DUE TO (c) Generalized Arteriosclerosis | | | | | | Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1930 to April 17, 1962 , that (I) (we) last saw the deceased alive on April 17, 1962 , and that death occurred at 8:30 P , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Wetherbee Fort | | | | M.D.
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
Wetherbee Fort | | | | 22d. ADDRESS
6 Sutton Ave, Catonsville, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF
4-19-62 | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park Cm. | | 23d. LOCATION (City, town or county) (State)
Woodlawn Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Foley Funeral Home - Catonsville | | | | 25a. REC'D BY REGISTRAR
APR 23 '62 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Hume | |

TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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TO HOSPITAL, 3 ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04262 CERTIFICATE OF DEATH 04259

| | | | | | |
|--|---------------------------|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTO. CO.</u> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3 STANLEY DRIVE</u> | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X CATONSVILLE</u>
d. STREET ADDRESS <u>13 STANLEY DRIVE</u>
a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) <u>ADAH D JOHNSON</u> | | | 4. DATE OF DEATH <u>APRIL 6 1962</u> | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/18/93</u> | 9. AGE (In years last birthday) <u>68</u> yrs. | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>W. Va.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Cornelius Dinstrow</u> | | | 14. MOTHER'S MAIDEN NAME <u>Kauffman</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes give year or dates of service) | | 17. INFORMANT <u>Family records</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Degenerative C.V. D Failure</u>
<u>4-20-1</u> DUE TO <u>Coronary Thrombosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>ASCD</u>
(b) (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 day</u>
<u>3 mon</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-4-62</u> to <u>4-6-62</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>4-6-62</u> and that death occurred <u>6:30 PM</u> from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE <u>James Dinstrow</u> M.D. | | | 22b. DATE SIGNED <u>4-7</u> | | |
| 22c. PHYSICIAN'S NAME (Type) | | | 22d. ADDRESS <u>Catonville</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>4/9/62</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u> | | 23d. LOCATION (City, town or county) (State) <u>Balto. Co. Md.</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Nabbs & Son</u> | | | 25a. REC'D BY REGISTRAR <u>301 Frederick</u> ADDRESS <u>Balto. 28 Md</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u> |
| | | | 25a. DATE <u>APR 9 '62</u> | | |

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M

William L. Thomas

VR A15 (4)
15M 9/60

0-510

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1-1-71

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04261

Item 2 Film G312 5/7/62 iwk

| | | | |
|---|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Balto MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE Md b. COUNTY Balto | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Middle River | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Middle River Bradshaw | |
| c. LENGTH OF STAY IN lb
6 mos | | d. STREET ADDRESS
19 Harrison Avenue | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Ivy Hall Nursing Home | | a. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Edith Middle Jones Last Jones | | 4. DATE OF DEATH
Month 4 Day 30 Year 1962 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4-17-1879 |
| 9. AGE (In years last birthday)
83 yrs. | | 10. IF UNDER 1 YEAR
Months 8 Days 13 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Housewife | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore Md | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 13. FATHER'S NAME
Unknown Smith | | 14. MOTHER'S MAIDEN NAME
Edith Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Mr Charles Jones | | Address
4214 E. Joppa Road (36) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)
4201 Coronary occlusion
DUE TO
Arteriosclerotic Cardio-vascular disease
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.
DUE TO
5 yrs | | INTERVAL BETWEEN ONSET AND DEATH
Sudden | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. 19 p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 4/27 1962 to 4/30 1962 , that (I) (we) last saw the deceased alive on 4/29 1962 , and that death occurred at 2:30 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
G.M. Baumgardner M.D. | | 22b. DATE SIGNED
4/30/62 | |
| 22c. PHYSICIAN'S NAME (Type)
G.M. Baumgardner | | 22d. ADDRESS
Balto 6 Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-3-1962 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Salem Methodist Cemetery | | 23d. LOCATION (City, town or county) (State)
Bradshaw Md | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Lassen Funeral Home 7401 Belair Rd | | 25a. REC'D BY REGISTRAR
DATE MAY 2 '62 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04265

CERTIFICATE OF DEATH

04262

| | | | | | |
|--|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. LENGTH OF STAY IN 1b
77 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Veterans Administration Hospital | | | d. STREET ADDRESS
1733 Park Avenue | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print)
ALAN R. KELLEY | | | 4. DATE OF DEATH
April 26 1962 | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
December 31, 1894 | | 9. AGE (In years last birthday)
67 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machinist | | 10b. KIND OF BUSINESS OR INDUSTRY
Naval Gun Factory | | 11. BIRTHPLACE (County & State, or foreign country)
Washington, D. C. | |
| 13. FATHER'S NAME
Franklin Kelley | | 14. MOTHER'S MAIDEN NAME
Mary Turnbaugh | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
Yes WWII | | 16. SOCIAL SECURITY NO.
212-03-4264 | | 17. INFORMANT Clinical Records, VA Hospital
Fort Howard, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)
420.0 DUE TO
ARTERIOSCLEROTIC HEART DISEASE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO
PULMONARY EMPHYSEMA. ENCEPHALMALACIA
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
PULMONARY EMPHYSEMA. ENCEPHALMALACIA
INTERVAL BETWEEN ONSET AND DEATH
RECENT
UNKNOWN
20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from February 8, 1962, to April 26, 1962, that (X) (we) last saw the deceased alive on April 26, 1962, and that death occurred at 10:30 A.M. from the causes and on the date stated above.
22a. SIGNATURE
Thomas F. Crahan M.D.
22b. DATE SIGNED
4/26/62
22c. PHYSICIAN'S NAME (Type)
THOMAS F. CRAHAN, M. D.
22d. ADDRESS
VAH, FT. HOWARD, MARYLAND
23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial
23b. DATE THEREOF
4-30-62
23c. NAME OF CEMETERY OR CREMATORY
Balto. National Cemetery
23d. LOCATION (City, town or county) (State)
Balto. Maryland.
24. FUNERAL DIRECTOR'S SIGNATURE
Wm. Cook Blight Inc. 6009 Harford Rd. Balto. Md.
25a. REC'D BY REGISTRAR
MAY 2 '62
25b. REGISTRAR'S SIGNATURE
Cuthbert S. Thomas | | | | | |

M

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618-03-10-10

PULMONARY TUBERCULOSIS

ARTHRITIS OF THE NECK

PULMONARY TUBERCULOSIS

ARTHRITIS OF THE NECK

WILLIAM T. HOWARD, M.D.

WILLIAM T. HOWARD, M.D.

4-10-10

4-10-10

WILLIAM T. HOWARD, M.D.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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| <div>1</div> <div>04266</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> <div>04263</div> | | | | | | | | | | | |
|---|--|--|---|---|--|--|--|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY - | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | | | c. LENGTH OF STAY IN 1b
4yr1mth6days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | | d. STREET ADDRESS
131 Augusta Avenue | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print)
James Francis Kelly | | | 4. DATE OF DEATH
Month April Day 17 Year 62 | | | 5. SEX
male | | | 6. COLOR OR RACE
white | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 8. DATE OF BIRTH
Nov. 12, 1885 | | | 9. AGE (In years last birthday)
76 yrs. | | | IF UNDER 1 YEAR
Months 7 Days 19 Hours 62 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
auditor | | | | 10b. KIND OF BUSINESS OR INDUSTRY
B. & O. R.R. | | | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. | | | | | | 13. FATHER'S NAME
James Kelly | | | | | |
| 14. MOTHER'S MAIDEN NAME
Maggie Ryan | | | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
unknown | | | | | |
| 16. SOCIAL SECURITY NO.
218-14-7190 | | | | | | 17. INFORMANT
Address Records: SPRING GROVE STATE HOSPITAL | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute coronary occlusion | | | | | | | | | | | |
| DUE TO (b) 420 | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO (c) | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour 19 e.m.
p.m. | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
Baltimore | | (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 11, 1962 to April 17, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 17, 1962 , and that death occurred at 7:45 M, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Stella Wachsler M.D. | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 4-17-62 | | | 22b. DATE SIGNED | | |
| 22c. PHYSICIAN'S NAME (Type)
Stella Wachsler, M. D. | | | | | | 22d. ADDRESS
SPRING GROVE STATE HOSPITAL
Catonsville 28, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | 23b. DATE THEREOF
4/19/62 | | 23c. NAME OF CEMETERY OR CREMATORY
CATHEDRAL | | | | 23d. LOCATION (City, town or county) (State)
BALTIMORE, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
H. W. MEARS & SON 805 N. CALVERT ST. | | | | | | 25a. REC'D BY REGISTRAR
DATE APR 23 '62 | | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Thomas | | |

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BALTIMORE, MD.

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RECEIVED

H. H. BEARS & SON 305 N. ALBERT ST.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04267

CERTIFICATE OF DEATH

04264

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>
c. LENGTH OF STAY IN lb
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>113 Charmuth Rd.</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>
d. STREET ADDRESS <u>113 Charmuth Rd.</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>Charles</u> <u>David</u> <u>Kephart</u> | | | | 4. DATE OF DEATH
Month <u>April</u> Day <u>10</u> Year <u>1962</u> | | | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Nov. 6, 1920</u> | | 9. AGE (In years last birthday) <u>41</u> yrs.
IF UNDER 1 YEAR: Months <u> </u> Days <u> </u>
IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Postal Employee</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Government</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Carroll Co., Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Charles Burton Kephart</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Lelia Yount</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>Yes</u> <u>WW II</u> | | | | 16. SOCIAL SECURITY NO.
<u> </u> | | 17. INFORMANT
<u>Mrs. Martha Kephart, 113 Charmuth Rd., Lutherville, Maryland</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
<u>420.1</u> <u>Coronary Thrombosis</u>
IMMEDIATE CAUSE (a) <u> </u> DUE TO <u> </u>
Conditions, if any, which gave rise to immediate cause (b) <u> </u> DUE TO <u> </u>
(c), stating the underlying cause last. <u> </u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1-hour</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m. <u> </u> <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April 10, 1962</u> to <u>June 4, 1962</u> , that (I) (we) last saw the deceased alive on <u>April 10, 1962</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<u>George T. Gilmore</u> M.D. | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22b. DATE SIGNED <u>4/12/62</u> | | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>George T. Gilmore, M.D.</u> | | | | | 22d. ADDRESS
<u>Lanham Building Lutherville, Md.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>4/13/62</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Trinity Lutheran Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>Taneytown, Maryland</u> | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>John H. Stiles</u>
<u>C.O. Fuss & Son, Taneytown, Md.</u> | | | | | 25a. REC'D BY REGISTRAR
DATE <u>APR 16 '62</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles S. Hines</u> | | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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For a copy of the report...

James W. Collins, Jr.

April 1880

1880

George T. Oliver

James W. Collins, Jr.

George T. Oliver

James W. Collins, Jr.

April 1880

James W. Collins, Jr.

George T. Oliver

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

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MEDICAL CERTIFICATION

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|----------------------------------|--|---|--|---|--|---|--|--------------------------------|--|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | | | | | | | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE | | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
DUNDALK | | | | | | | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
DUNDALK | | | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
222 RIVERVIEW AVE | | | | | | | | | | | | d. STREET ADDRESS
222 RIVERVIEW AVE | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) RAYMOND FRANKLIN KERLEY | | | | | | | | | | | | 4. DATE OF DEATH APRIL 22 1962 | | | | | | | | | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH
APR 29 1946 | | 9. AGE (In years last birthday) 21 yrs. | | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
AUTO MECHANIC | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | | | 11. BIRTHPLACE (State or foreign country)
WEST VIRGINIA | | | | | | | | | | | |
| 12. CITIZEN OF WHAT COUNTRY
U.S.A. | | | | | | 13. FATHER'S NAME
ORVILLE H. KERLEY | | | | | | 14. MOTHER'S MAIDEN NAME
BEULAH GAY KINGREA | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | | | | 16. SOCIAL SECURITY NO. | | | | | | 17. INFORMANT Address
MRS SHIRLEY KERLEY-255 RIVERVIEW | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) INCINERATION - Residential Fire
911
Conditions, if any, which gave rise to immediate cause (b)
(c) DUE TO
(e), stating the underlying cause last. DUE TO | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 min | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | | | | | 2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Subject trapped in burning residence | | | | | | 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | | | | | | | | |
| 2Dd. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | | | | | 20f. (City or town) (County) (State)
Above Address | | | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
Address (Street, city, town, or county) | | | | | | | | | | | |
| ACTUAL SIGNATURE Jack C Collins M.D. | | | | | | | | | | | | DATE SIGNED 4 23 62 | | | | | | | | | | | |
| EXAMINER'S NAME (Type) JACK C Collins | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | 22b. DATE THEREOF
APR 25 1962 | | | | 22c. NAME OF CEMETERY OR CREMATORY
OAK LAWN | | | | 22d. LOCATION (City, town, or country) (State)
COLGATE MD | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR ADDRESS
ULLRICH FUNERAL HOME - DUNDALK MD | | | | | | | | | | | | 24a. REC'D BY REGISTRAR
APR 26 '62 | | | | | | | | | | | |
| | | | | | | | | | | | | 24b. REGISTRAR'S SIGNATURE
William S. Harris | | | | | | | | | | | |

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04269

CERTIFICATE OF DEATH

04266

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Rural- Catonsville | | c. LENGTH OF STAY IN 1b
2 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Shady Nook Nursing Home | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Rural- Rockdale | |
| | | d. STREET ADDRESS
3524 Rolling Road | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
Mr. John T.. Kirk | | 4. DATE OF DEATH
Month April Day 3 Year 19 62 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 7, 1889 |
| 9. AGE (In years last birthday)
72 yrs. | | IF UNDER 1 YEAR
Months 72 Days 0 Hours 0 Min. 0 | IF UNDER 24 HRS.
Months 0 Days 0 Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Service Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY
Automobile | 11. BIRTHPLACE (County & State, or foreign country)
Hebbsville, Maryland |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
John Kirk | | 14. MOTHER'S MAIDEN NAME
Charlotte Smith | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give year or dates of service)
No | | 16. SOCIAL SECURITY NO.
214-01-2299 | |
| 17. INFORMANT
Mr. John E. Kirk, Baltimore 7, Md. | | Address
3524 Rolling Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Broncho-pneumonia
DUE TO (b) Metastatic Carcinoma of breast
DUE TO (c) Carcinoma of Prostate
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. | | | |
| INTERVAL BETWEEN ONSET AND DEATH
36 hrs
4 Days
One year | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
et work <input type="checkbox"/> et work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from April 1st - 62 to April 3, 1962. That (I) (we) last saw the deceased alive on April 3, 1962, and that death occurred at 10 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Wm. nber Fort | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 4/5/62 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Wetherbee Fort | | 22d. DATE SIGNED
4/5/62 | |
| 22e. ADDRESS
6 Dutton Ave., Baltimore 28, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4-7-62 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olive Cemetery | | 23d. LOCATION (City, town or county) (State)
Randallstown, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Long Byers | | 25a. REC'D BY REGISTRAR
DATE APR 9 '62 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur L. Thane | | | |

01588

CERTIFICATE OF DEATH

1958

M

1958

1958

1958

Prostate Gland
Necrotic carcinoma of prostate
Gland of prostate

1958

1958

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04270

CERTIFICATE OF DEATH

04267

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY - | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 6 Days | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital | | e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore | |
| 3. NAME OF DECEASED (Type or print) DANIEL First Middle Last | | d. STREET ADDRESS 102 West Ostend Street | |
| 5. SEX Male | | 6. DATE OF DEATH April 8 19 62 | |
| 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH August 27, 1888 73 yrs. | |
| 8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. AGE (In years last birthday) 73 yrs. | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland | |
| 13. FATHER'S NAME Albert Klein | | 14. MOTHER'S MAIDEN NAME Madeline Bixler | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give year or dates of service) WW-1 | | 16. SOCIAL SECURITY NO. WW-1 | |
| 17. INFORMANT Clinical Records, VAH, Fort Howard, Maryland | | Address U.S.A. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) SQUAMOUS CELL CARCINOMA, HYPOPHARYNX AND ROOT OF TONGUE
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. METASTASIS TO LUNGS AND REGIONAL LYMPH NODES
DUE TO UNKNOWN UNKNOWN | | INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) BILATERAL PNEUMONIA - 5 DAYS | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year 19 Hour e.m. p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 2, 1962 to April 8, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 8, 1962 , and that death occurred at 10:00 P.M. from the causes and on the date stated above. | | | |
| 22e. SIGNATURE Sebastian Russo M.D. | | 22b. DATE SIGNED 4/9/62 | |
| 22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D. | | 22d. ADDRESS VAH, FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 4/12/62 | |
| 23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery | | 23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE James L. McCully | | 25a. REC'D BY REGISTRAR DATE APR 13 '62 | |
| ADDRESS 128 E. Fort Avenue, Balto. Md. | | 25b. REGISTRAR'S SIGNATURE Arthur S. Hanna | |

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FOR THE DIRECTOR

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04271

04268

| | | | | | | | |
|---|---|---|---|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore County
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Mt. Wilson, Maryland
c. LENGTH OF STAY IN 1b
12 days.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Mt. Wilson State Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MARYLAND b. COUNTY ✓
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
BALTIMORE CITY
d. STREET ADDRESS
1901 ALICEANNE STREET
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
ALFRED | | First Middle Last
KOWALEWSKI | | 4. DATE OF DEATH
Month Day Year
APRIL 18 1962 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3/29/08 | | 9. AGE (In years last birthday) 54 yrs.
IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/>
IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
BUILDING MAINTENANCE | | 10b. KIND OF BUSINESS OR INDUSTRY
MISSISSIPPI | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 13. FATHER'S NAME
JOSEPH KOWALEWSKI | | | 14. MOTHER'S MAIDEN NAME
ROSIE ? | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
705-10-9090 | | 17. INFORMANT
Address
Hospital Records, Mt. Wilson State Hospital | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Tuberculosis
002.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)
(c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
CHRONIC ALCOHOLISM | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 4/6 1962 to 4/18 1962 that (I) (we) last saw the deceased alive on 4/18 1962 and that death occurred 11:45 P. M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Wm. Newcomer, M.D., Superintendent | | | | 22b. DATE SIGNED
4/19/62 | | | |
| 22c. PHYSICIAN'S NAME (Type)
Wm. Newcomer, M.D., Superintendent | | | | 22d. ADDRESS
Mt. Wilson State Hospital, Mt. Wilson, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial 4/23/62 | | 23b. DATE THEREOF
4/23/62 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Rosary | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Fred W. Ozagowski | | 25a. REC'D BY REGISTRAR
APR 23 '62 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Hanes | | | |

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **01269**

04272

| | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY - | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
126 N. Symington Ave. 28 | | | | d. STREET ADDRESS
830 N. Lakewood Ave. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First ANNA Middle S. Last KRIZEK | | | | 4. DATE OF DEATH
Month April Day 8 Year 1962 | | | | | |
| 5. SEX
female | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
10/1/1884 | | | |
| 9. AGE (In years last birthday) yrs.
77 | | IF UNDER 1 YEAR
Months - Days - Hours - Min. - | | IF UNDER 24 HRS.
Hours - Min. - | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
tailoring | | | |
| 11. BIRTHPLACE (State or foreign country)
Czechoslovakia | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | | 13. FATHER'S NAME
unknown | | 14. MOTHER'S MAIDEN NAME
unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
217-09-9051 | | | | 16. SOCIAL SECURITY NO.
217-09-9051 | | | | | |
| 17. INFORMANT
Marie Wessel, 126 N. Symington Ave. 28 | | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) myocardial infarction
DUE TO coronary thrombosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C-V Disease - Coronary Arteriosclerosis
DUE TO (c) ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ? | | | | INTERVAL BETWEEN ONSET AND DEATH
1 hr. 2 mos. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that 4/7 attended the deceased from 4/7 , 19 62 to 4/8 , 19 62 , that I lost saw the deceased alive on 4/7 , 19 62 , and that death occurred at 11 A. M. from the causes and on the date stated above. | | | | | | | | | |
| ACTUAL SIGNATURE Kenneth Spulowitz M.D. | | | | ADDRESS (Street, city or town, state) 1002 Ingleside Ave Baltimore, Md. | | | | | |
| PHYSICIAN'S NAME (Type) Kenneth Spulowitz, MD. | | | | DATE SIGNED 4/10/62 | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
4/12/62 | | 22c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cem. | | 22d. LOCATION (City, town, or county) (State)
Baltimore, Md. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Schimunek Funeral Home, Inc.
2601 E. Madison St. | | | | 24a. REC'D BY REGISTRAR
DATE APR 12 '62 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04273

CERTIFICATE OF DEATH

Reg. Dist. No. 04270

| | | | |
|---|---------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore Co. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Md. b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Balto. Md. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore Rural | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
St. Josephs Nursing Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) ZUZANNA KROLICKA | | 4. DATE OF DEATH April 11, 1962 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/27/1880 |
| 9. AGE (In years last birthday) 81 yrs. | | IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Packing House | |
| 11. BIRTHPLACE (State or foreign country) Poland | | 12. CITIZEN OF WHAT COUNTRY? Poland | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 217-01-9660A | |
| 17. INFORMANT Sophia Krolicka | | Address 2219 Orem Ave. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 422.1 Congestive heart failure
DUE TO (b) Arteriosclerotic cardiovascular
DUE TO (c) 10 yrs +
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH 7d | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinsonism | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan. 1962 to April 1962 , that I last saw the deceased alive on 11 April 1962 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) April 13, 1962
DATE SIGNED | | | |
| ACTUAL SIGNATURE James E. Rowe M.D. | | DATE SIGNED April 13, 1962 | |
| PHYSICIAN'S NAME (Type) James E. Rowe, M. D. | | 1011 Frederick Road, Catonsville 28, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4/14/62 | |
| 22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore Co. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John M. Weber & Sons | | ADDRESS 401 S. Chester St | |
| 24a. REC'D BY REGISTRAR APR 13 '62 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

04274

04271

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Arbutus</u> | | | | c. LENGTH OF STAY IN 1b
<u>25 yrs</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>5311 La Mar Ave</u> | | | | d. STREET ADDRESS
<u>5311 La Mar Ave</u> | | | |
| 3. NAME OF DECEASED
(Type or print)
<u>Annie May LaMar</u> | | | | 4. DATE OF DEATH
Month <u>April</u> Day <u>3</u> Year <u>1962</u> | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>July 5, 1873</u> | |
| 9. AGE (In years last birthday)
<u>88</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housework</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>William K. LaMar</u> | | 14. MOTHER'S MAIDEN NAME
<u>Annie B. Cromwell</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT
<u>Walter LaMar</u> | | Address
<u>5623 Gordenville Ave</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u>
420.1 DUE TO <u>Chronic Cardiovascular Disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Senility</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>10 yrs</u>
<u>10 yrs</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. <u> </u> p.m. <u> </u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>March 1961</u> to <u>April 3, 1962</u> , that (I) (we) last saw the deceased alive on <u>April 2, 1962</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>B B Broombaugh M.D.</u> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>4/4/62</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>B B Broombaugh</u> | | | | 22d. ADDRESS
<u>5609 Main St. Edgemoor, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>4/7/62</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>St Olives Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>Frederick, Frederick Maryland</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Ambruse Inc. 1328 Sulphur Spring Rd.</u> | | | | 25. REC'D BY REGISTRAR
DATE <u>APR 6 '62</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | |



25820

17910

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film G312 5/7/62 iwk

CERTIFICATE OF DEATH

Item 2 Film G313 5/17/62 mh

Reg. Dist. No. 04272

04275

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> <u>Catonsville</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> | | | | c. LENGTH OF STAY IN 1b
<u>11 months</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Caton Ridge Nursing Home</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<u>Rose or Rosalie</u> <u>Larson</u> | | | | 4. DATE OF DEATH Month Day Year
<u>April</u> <u>28</u> <u>1962</u> | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>March 7 1892</u> | |
| 9. AGE (In years last birthday) yrs.
<u>70</u> | | IF UNDER 1 YEAR Months Days Hours Min.
<u>70</u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Chamber Maid</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Retired</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Germany</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | |
| 13. FATHER'S NAME
<u>John Hubbe</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Margaret Gettman</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>219-28-6366</u> | | 17. INFORMANT Address
<u>Mrs Lillian Czaykowski 33 S. Decker Ave</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)
<u>422.1</u> DUE TO <u>Cardiac failure</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> (c) <u>Cardiovascular disease</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 days</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
<u>4/27</u> <u>1962</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>4/27</u> , 19 <u>62</u> , to <u>4/28</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>4/27</u> , 19 <u>62</u> , and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Cliff Ratliff</u> | | | | ADDRESS (Street, city or town, state) <u>4605 Edmondson Avenue</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Cliff Ratliff, Jr., M.D.</u> | | | | DATE SIGNED <u>4/30/62</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>May 1st 1962</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Swarth</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Baltimore 29, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Frank Della Noce</u> | | | | ADDRESS
<u>322 S. High St</u> | | 24a. REC'D BY REGISTRAR
<u>MAY 2 '62</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Thomas</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04276 CERTIFICATE OF DEATH 04273

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Calvert | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
8mthldy | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | e. STREET ADDRESS
none | |
| 3. NAME OF DECEASED
(Type or print)
Alexander Roland Lauer | | 4. DATE OF DEATH
Month April Day 8 Year 1962 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 3, 1934 |
| 9. AGE (In years last birthday)
28 yrs. | | 10. IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farming | | 11b. KIND OF BUSINESS OR INDUSTRY
Farmer | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. | | 13. FATHER'S NAME
Roland Lauer | |
| 14. MOTHER'S MAIDEN NAME
unknown Mary Stallings | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)
unknown-No | |
| 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fatty Liver due to undetermined cause
DUE TO
581-10 }
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
Urinary cystitis; acute left pyelitis | | INTERVAL BETWEEN ONSET AND DEATH
days | |
| 20c. TIME OF INJURY
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that the (this hospital) attended the deceased from April 7, 1962 to April 8, 1962 , that it (we) last saw the deceased alive on April 8, 1962 and that death occurred at 7:00 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Jose R. Arizaga, M.D. | | 22b. DATE SIGNED
April 8, 1962 | |
| 22c. PHYSICIAN'S NAME (Type)
JOSE R. ARIZAGA, M.D. | | 22d. ADDRESS
SPRING GROVE STATE HOSPITAL
Catonsville 28, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
April 10, 1962 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Mt. Harmony Cemetery | | 23d. LOCATION (City, town or county) (State)
near Owings, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Hutchins Funeral Home | | 25a. REC'D BY REGISTRAR
APR 12 '62 | |
| ADDRESS
Owings Md. | | 25b. REGISTRAR'S SIGNATURE
Arthur J. Arzaga | |

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR AIS (4)
15M 7/61

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---|--|---|---|---|--|---|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 04277 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard
c. LENGTH OF STAY IN 1b
14 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Veterans Administration Hospital | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
e. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore
d. STREET ADDRESS
1973 Snyder Ave
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
HAROLD W LETTS | | | | | 4. DATE OF DEATH
Month Day Year
April 19 1962 | | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
April 12, 1899 | | 9. AGE (In years last birthday) yrs. Months Days
63 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Bartender | | | | | 10b. KIND OF BUSINESS OR INDUSTRY
- - | | 11. BIRTHPLACE (County & State, or foreign country)
Charleston, S. C | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
Joseph W. Letts | | | | | 14. MOTHER'S MAIDEN NAME
Caroline Kelly | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
yes | | | | | 16. SOCIAL SECURITY NO.
WW I 220-30-3797 | | 17. INFORMANT
Clinical Records, VAH Ft Howard, Maryland | | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SQUAMOUS CELL CARCINOMA RIGHT LUNG WITH METASTASES TO RIGHT KIDNEY AND TAIL OF PANCREAS
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) UNK
(c) DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
163 X XXXX | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
UNK | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
April 5 1962 | | 20g. (County)
April 19 1962 | | 20h. (State)
MD | |
| 21. I certify that (this hospital) attended the deceased from April 5 1962 to April 19 1962 , that (we) last saw the deceased alive on April 19 1962 , and that death occurred at 8:40 PM , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Sebastian Russo | | | | | 22b. DATE SIGNED
4/20/62 | | 22c. PHYSICIAN'S NAME (Type)
SEBASTIAN RUSSO, M.D. | | | 22d. ADDRESS
VAH FT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4-23-62 | | 23c. NAME OF CEMETERY OR CREMATORY
Balto. National Cemetery | | 23d. LOCATION (City, town or county)
Balto. Maryland. | | 23e. STATE
Md | | 23f. BY REGISTRAR | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Wm. Cook Blight Inc. 6009 Harford Rd. Balto. 14 | | | | | 24a. ADDRESS
6009 Harford Rd. Balto. 14 | | 24b. DATE
APR 24 '62 | | 24c. REGISTRAR'S SIGNATURE
Arthur S. Hume | | |

04373

CERTIFICATE OF DEATH

State of Maryland
County of Prince George's
I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the 1st day of May, 1968, at the residence of the deceased, I examined the body of
Name of Deceased
Age
Sex
Race
Cause of Death
Manner of Death
Signature of Physician
Date

Witness my hand and the seal of the State of Maryland, this 1st day of May, 1968.
Signature of Registrar
Seal of the State of Maryland
Date

Official Record of the State of Maryland
Date of Birth
Date of Death
Signature of Registrar
Seal of the State of Maryland
Date

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04278

04275

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard
c. LENGTH OF STAY IN 1b MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS 1009 Sumpter Avenue
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First JOHN Middle H. Last LITTLE | | | | 4. DATE OF DEATH
Month APRIL Day 9 Year 1962 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3/18/05 | |
| 9. AGE (In years last birthday) 57 yrs. | | IF UNDER 1 YEAR
Months 5 Days 18 | | IF UNDER 24 HRS.
Hours 18 Min. 57 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur | | | | 10b. KIND OF BUSINESS OR INDUSTRY Steel Company | | 11. BIRTHPLACE (State or foreign country) Texas, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Harry Little | | | | 14. MOTHER'S MAIDEN NAME Annie Kessler | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 12/27/27; 5/14/28 | | | | 16. SOCIAL SECURITY NO. 216-07-2897 | | | |
| 17. INFORMANT Clin. Rec. VAH, Fort Howard, Maryland | | | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MASSIVE PULMONARY INFARCT
DUE TO
Conditions, if any, which gave rise to immediate cause (b) ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE
DUE TO
(c) 422-1 | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 5 MINUTES | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. --- | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) --- | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. --- p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --- | | 20f. (City or town) --- (County) --- (State) --- | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE M. B. Davis | | | | M.D. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) M. B. DAVIS, M.D. | | | | Address (Street, city, town, or county) 4/9/62 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4-12-62 | | 22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery | | 22d. LOCATION (City, town, or country) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR ADDRESS Cvach Funeral Home, 1211 Chesaco Ave. Rosedale, Md. | | | | 24e. REC'D BY REGISTRAR APR 17 '62 24b. REGISTRAR'S SIGNATURE Arthur S. Truax | | | |

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INDEX OF EXHIBITS FOR CASE NO. 1272

Exhibit 1

Exhibit 2

Exhibit 3

Exhibit 4

Exhibit 5

Exhibit 6

Exhibit 7

Exhibit 8

Exhibit 9

Exhibit 10

Exhibit 11

Exhibit 12

Exhibit 13

Exhibit 14

Exhibit 15

Exhibit 16

Exhibit 17

Exhibit 18

Exhibit 19

Exhibit 20

Exhibit 21

Exhibit 22

Exhibit 23

Exhibit 24

Exhibit 25

Exhibit 26

Exhibit 27

Exhibit 28

Exhibit 29

Exhibit 30

Exhibit 31

Exhibit 32

Exhibit 33

Exhibit 34

Exhibit 35

TO HOSPITAL OR A DEDICATED PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04279

04276

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ROSEDALE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X BALTIMORE | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Rosedale Medical Center | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First ALICE Middle E. Last MADDOX | | 4. DATE OF DEATH
Month APRIL Day 18 Year 1962 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 6, 1915 |
| 9. AGE (In years last birthday)
46 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CASHIER | | 10b. KIND OF BUSINESS OR INDUSTRY
Hochschild, Kohn | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Guy Holditch | | 14. MOTHER'S MAIDEN NAME
Nellie Lutz | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
215-03-1448 | |
| 17. INFORMANT
Robert L. Maddox | | Address
523 S. 46th Street, Zone 24 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) HYPERTENSIVE HEART DISEASE
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH _____ | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from APRIL 18, 1962 to APRIL 18, 1962 that (I) (we) last saw the deceased alive on APRIL 18, 1962 and that death occurred at 4:53 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
John G. Orth, M.D. | | 22b. DATE SIGNED
4/18/62 | |
| 22c. PHYSICIAN'S NAME (Type)
JOHN G. ORTH | | 22d. ADDRESS
8019 PHILADELPHIA ROAD | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
4-21-62 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Cemetery | | 23d. LOCATION (City, town, or county) (State)
Elkridge, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Wm. Cook, Inc., 1217 St. Paul Street, Zone 2 | | 25a. REC'D BY REGISTRAR
APR 23 '62 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

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(M)

UNITED STATES DEPARTMENT OF HEALTH
CENTRAL BUREAU OF VITAL STATISTICS
WASHINGTON, D. C.

Birth Record

Name: [illegible]
Sex: [illegible]
Date of Birth: [illegible]
Place of Birth: [illegible]
Maiden Name: [illegible]
Father's Name: [illegible]
Mother's Name: [illegible]
Occupation: [illegible]
Religion: [illegible]
Marital Status: [illegible]
Signature: [illegible]
Date: [illegible]

CERTIFICATE OF DEATH

Reg. Dist. No.

04280

04277

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>-</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3401-4</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Holly Hill Manor Nursing Home</u> | | | | d. STREET ADDRESS <u>27 N. Potomac Street</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Sigvart</u> Middle <u>Martinson</u> Last <u>Martinson</u> | | | | 4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1962</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>October 28, 1875</u> | |
| 9. AGE (In years last birthday) <u>86</u> yrs. | | IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u> | | IF UNDER 24 HRS. Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u> | | 11. BIRTHPLACE (State or foreign country) <u>Norway</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Martin Martinson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>216-10-8742</u> | | 17. INFORMANT <u>Lydia Johnson</u> Address <u>428 N. East Ave. Balto.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
<u>332x</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u>
DUE TO (c) <u>senile</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <u>19</u> p. m. <u>-</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>4/10/62</u> , 19 <u>62</u> , to <u>4/25/62</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>4/24/62</u> , 19 <u>62</u> , and that death occurred at <u>12:45 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Lauren J. Lewis</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>11 E. Church</u> | | DATE SIGNED <u>4/27/62</u> | |
| PHYSICIAN'S NAME (Type) <u>Brewer & Mc</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>4/28/62</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u> ADDRESS <u>3000 E. Baltimore St.</u> | | | | 24a. REC'D BY REGISTRAR <u>MAY 1 1962</u> | | 24b. REGISTRAR'S SIGNATURE <u>John A. Moran</u> | |

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

04280



| | | | | | |
|--|--|--|--|---|--|
| NAME OF DECEASED
[Faint text, possibly "JAMES M. ..."] | | SEX
[Faint text, possibly "Male"] | | RACE
[Faint text, possibly "White"] | |
| DATE OF BIRTH
[Faint text, possibly "1910-01-01"] | | PLACE OF BIRTH
[Faint text, possibly "Baltimore, Md"] | | CITY OF BIRTH
[Faint text, possibly "Baltimore"] | |
| DATE OF DEATH
[Faint text, possibly "1910-01-01"] | | PLACE OF DEATH
[Faint text, possibly "Baltimore, Md"] | | CITY OF DEATH
[Faint text, possibly "Baltimore"] | |
| TIME OF DEATH
[Faint text, possibly "10:00 AM"] | | CAUSE OF DEATH
[Faint text, possibly "Heart Disease"] | | MANNER OF DEATH
[Faint text, possibly "Natural"] | |
| SIGNATURE OF PHYSICIAN
[Faint text, possibly "J. M. ..."] | | SIGNATURE OF CORONER
[Faint text, possibly "J. M. ..."] | | SIGNATURE OF WITNESS
[Faint text, possibly "J. M. ..."] | |
| SIGNATURE OF DECEASED
[Faint text, possibly "J. M. ..."] | | SIGNATURE OF NEXT OF KIN
[Faint text, possibly "J. M. ..."] | | SIGNATURE OF BURIAL SOCIETY
[Faint text, possibly "J. M. ..."] | |

RECEIVED BY THE STATE DEPARTMENT OF HEALTH

RECEIVED BY THE STATE DEPARTMENT OF HEALTH
 BALTIMORE, MD
 JAN 1 1910

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

04278
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgemere
c. LENGTH OF STAY IN 1b 26 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Res. 2513 Sparrows Point Rd. | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgemere
d. STREET ADDRESS 3014 Ritchie Avenue
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Dewey First Sanson Middle Mason Last
4. DATE OF DEATH 4 - 14 - 1962
Month Day Year | | 5. SEX Male
6. COLOR OR RACE White
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Nov. 23, 1898
9. AGE (In years last birthday) 63 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-Employed-- Barber
10b. KIND OF BUSINESS OR INDUSTRY Barber
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME George Mason
14. MOTHER'S MAIDEN NAME Lula V. Ward | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
16. SOCIAL SECURITY NO. 216-07-1740
17. INFORMANT Mrs. Virginia Mason Address 3014 Ritchie Ave. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
DUE TO 420
Conditions, if any, which gave rise to immediate cause (b) 420
(c) 420
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetes
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour o.m. 19 p.m.
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER Jack C Collins
M.D. ASSISTANT MEDICAL EXAMINER 4-14-62 DATE SIGNED
DEPUTY MEDICAL EXAMINER Jack C Collins
Address (Street, city, town, or county) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 4-18-1962
22c. NAME OF CEMETERY OR CREMATORY Halls Hill
22d. LOCATION (City, town, or country) (State) Pocomoke City Md. | | 23. FUNERAL DIRECTOR JOHN J. DUDA ADDRESS 7922 Wise Ave. 22, Md.
24a. REC'D BY REGISTRAR APR 17 '62
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas | |

MEDICAL CERTIFICATION

1942

James H. Collins

James H. Collins

James H.

James H. Collins

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04282

04279

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard
c. LENGTH OF STAY IN 1b 17 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn
d. STREET ADDRESS Route 1 Box 359A Danza Road
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) CIARENCE G. MAYR | | 4. DATE OF DEATH
Month April Day 1 Year 1962 | | 5. SEX
Male | | | |
| 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
April 19, 1915 | | | |
| 9. AGE (In years last birthday) 46 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Chauffer | | 10b. KIND OF BUSINESS OR INDUSTRY
Transfer Co. | | | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 13. FATHER'S NAME
Clarence G. Mayr | | | |
| 14. MOTHER'S MAIDEN NAME
Gertrude Grief | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) Yes WW II | | 16. SOCIAL SECURITY NO.
215-05-0421 | | | |
| 17. INFORMANT
Address Clinical Records, VAH, Fort Howard, Maryland | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESIDUAL SQUAMOUS CELL CARCINOMA, RIGHT LUNG
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BILATERAL PNEUMONIA
(c) METASTASIS TO STERNUM, RIBS AND RIGHT KIDNEY
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | INTERVAL BETWEEN ONSET AND DEATH
UNKNOWN
5 DAYS
UNKNOWN | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour a.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town)
March 15, 1962 | | 20g. (County)
April 1, 1962 | | 20h. (State) | | | |
| 21. I certify that he (this hospital) attended the deceased from March 15, 1962 to April 1, 1962 that he (we) last saw the deceased alive on April 1, 1962 and that death occurred at 1 p.m. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
SEBASTIAN RUSSO, M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
4/2/62 | | | |
| 22c. PHYSICIAN'S NAME (Type)
SEBASTIAN RUSSO, M.D. | | 22d. ADDRESS
VA HOSPITAL, FORT HOWARD, MARYLAND | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-4-1962 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | | |
| 23d. LOCATION (City, town or county)
Ritchie Highway, Glen Burnie, Md. | | 23e. REC'D BY REGISTRAR | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Richard W. Singleton | | 24a. ADDRESS
Glen Burnie, Maryland | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Thomas | | | |
| 24c. DATE
APR 5 '62 | | 24d. ADDRESS
Singleton Funeral Home, 200 Crain Highway, S W | | | | | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

22840



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12-11-1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04283

CERTIFICATE OF DEATH

Reg. Dist. No. 04280

| | | | |
|---|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE | | c. LENGTH OF STAY IN 1b 1 WEEK | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HOUSE IN THE PINES, FUSTING AVE | | d. STREET ADDRESS 4225 WICKFORD RD. | |
| 3. NAME OF DECEASED (Type or print) ELIZABETH M. Mc GOVERN | | 4. DATE OF DEATH APR. 2 1962 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH ABOUT 74 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PUB. HEALTH NURSE, BALTO. | | 10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE, MD. | |
| 11. BIRTHPLACE (State or foreign country) BALTIMORE, MD. | | 12. CITIZEN OF WHAT COUNTRY CLARA M. McGOVERN | |
| 13. FATHER'S NAME JAMES P. McGOVERN | | 14. MOTHER'S MAIDEN NAME CLARA SHAUGHNESSY | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT CLARA M. McGOVERN | | Address 4225 WICKFORD RD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Bladder
181.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 181.0 DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHIECTASIS - ARTERIOVENOUS HEART DISEASE | | INTERVAL BETWEEN ONSET AND DEATH 6 mos. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 1, 1950 to Apr 2, 1962 , that I last saw the deceased alive on Apr 1, 1962 , and that death occurred at 8 A M , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE M. W. JACOBSON | | ADDRESS (Street, city or town, state) 6821 Reisterstown Rd, Balt DATE SIGNED 4-3-62 | |
| PHYSICIAN'S NAME (Type) M. W. JACOBSON MD | | Baltimore Md | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 4/5/62 | |
| 22c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL | | 22d. LOCATION (City, town, or county) (State) BALTIMORE, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE H. W/ MEARS & SON | | 24a. REC'D BY REGISTRAR APR 6 '62 24b. REGISTRAR'S SIGNATURE Arthur L. Hume | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|------------------|--|----------------|--|----------------|--|-----------------|--|------------------|--|----------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF DEATH | | PLACE OF DEATH | |
| J. B. ... | | ... | | ... | | ... | | ... | | ... | |
| RESIDENCE | | OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | | CERTIFICATE NO. | | FILE NO. | |
| ... | | ... | | ... | | ... | | ... | | ... | |
| DATE OF BIRTH | | PLACE OF BIRTH | | EDUCATION | | MARRIAGE | | PREVIOUS ILLNESS | | HISTORY | |
| ... | | ... | | ... | | ... | | ... | | ... | |
| DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | CERTIFICATE NO. | | FILE NO. | |
| ... | | ... | | ... | | ... | | ... | | ... | |
| DATE OF BIRTH | | PLACE OF BIRTH | | EDUCATION | | MARRIAGE | | PREVIOUS ILLNESS | | HISTORY | |
| ... | | ... | | ... | | ... | | ... | | ... | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04284

04281

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> | | | |
| c. LENGTH OF STAY IN 1b | | | | d. STREET ADDRESS <u>Chattolantee & Valley Roads</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Chattolantee & Valley Roads</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Priscilla</u> <u>Stewart</u> <u>McHenry</u> | | | | 4. DATE OF DEATH <u>April 7</u> <u>19 62</u> | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>6-11-1876</u> | |
| 9. AGE (In years last birthday) <u>85</u> yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. PLACE (County & State, or foreign country) <u>Maryland</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>Charles Morton Stewart</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Josephine Lurham</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>--</u> | | | |
| 17. INFORMANT <u>James McHenry</u> Address <u>Glyndon Maryland</u> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
<u>4</u> IMMEDIATE CAUSE (a) <u>arterio-sclerotic cardio</u>
<u>4</u> DUE TO <u>Vascular renal disease.</u>
<u>2X</u> DUE TO <u>Parkinson's disease.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>10 years</u>
<u>2 years</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour e.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb 18, 1942</u> to <u>April 7, 1962</u> that (I) <u>(no)</u> last saw the deceased alive on <u>Apr 7, 1962</u> and that death occurred at <u>11</u> M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Palmer F. C. Williams</u> M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>Apr 9, 62</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Palmer F. C. Williams</u> | | | | 22d. ADDRESS <u>Owings Mills, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>4-10-62</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas'</u> | | 23d. LOCATION (City, town or county) (State) <u>Garrison Forest Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins & Sons Co.</u> ADDRESS <u>4905 York Rd., Balto., Md.</u> | | | | 25a. REC'D BY REGISTRAR <u>APR 12 '62</u> | | 25b. REGISTRAR'S SIGNATURE <u>Clinton L. Howard</u> | |

18510

18530

11-11-1851

Received of the
Treasury of the United States
the sum of \$100.00
for the purchase of
land in the
County of ...
State of ...

Received of the
Treasury of the United States
the sum of \$100.00
for the purchase of
land in the
County of ...
State of ...

11-11-1851

Received of the Treasury of the United States the sum of \$100.00 for the purchase of land in the County of ... State of ...

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

| MAY 18-21 Film 311 4-24-62 sms | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| MAY 18-21 Film 311 4-24-62 sms | | | | | | | | | | | |
| MAY 18-21 Film 311 4-24-62 sms | | | | | | | | | | | |
| MAY 18-21 Film 311 4-24-62 sms | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore County MARYLAND | | | | | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON c. LENGTH OF STAY IN 1b Towson | | | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 214 Burke Avenue 214 Burke Avenue | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) ANGELIA V. MCMAHON 4. DATE OF DEATH April 16, 1962 | | | | | | | | | | | |
| 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH MAY 27, 1893 9. AGE (In years last birthday) 68 10. IF UNDER 1 YEAR 167 yrs. 11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK - RETIRED 10b. KIND OF BUSINESS OR INDUSTRY FED. RES. BANK 11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | | | |
| 13. FATHER'S NAME John McMahon 14. MOTHER'S MAIDEN NAME Alice Schannessy | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. Family Records 17. INFORMANT Family Records Address | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Drowning
929.0 DUE TO
Conditions, if any, which gave rise to immediate cause (b) 929.0
(a), stating the underlying cause last. DUE TO (c) | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute alcoholism and arteriosclerotic cardiovascular disease 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE OF DEATH: PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Found with head under water in bathtub 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year 3:00 P.m. April 16, 1962 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Towson (County) Baltimore (State) Md. | | | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Howard G. Shaub M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED April 17, 1962 | | | | | | | | | | | |
| EXAMINER'S NAME (Type) HOWARD G. SHAUB, M. D. Address (Street, city, town, or county) April 17, 1962 | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF Apr. 18, 1962 22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem. 22d. LOCATION (City, town, or country) Baltimore, Md. | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR John Burke's Sons, Towson, Md. ADDRESS John Burke's Sons, Towson, Md. 24a. REC'D BY REGISTRAR APR 19 '62 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | | | | | | | | | |

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TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
04286
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
04283

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY - | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. LENGTH OF STAY IN 1b
one month | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | d. STREET ADDRESS
301 Northway | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Towson Convalescent Home | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
David Lyon Mc Pherson Sr. | | | | 4. DATE OF DEATH
Month April Day 14 Year 19 62 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
July 29, 1864 | |
| 9. AGE (In years last birthday)
97 yrs. | | IF UNDER 1 YEAR
Months 0 Days 0 | | IF UNDER 24 HRS.
Hours 0 Min. 0 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Builder (Retired) | | 10b. KIND OF BUSINESS OR INDUSTRY
Construction | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John McPherson | | | | 14. MOTHER'S MAIDEN NAME
Sarah Lyon | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Miss Helen McPherson #301 Northway | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease
DUE TO
Conditions, if any, which gave rise to immediate cause (b) 420.0
(a), stating the underlying cause listed. (c) DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH
13 mo. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. 19
p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 10/6 , 19 48 to 4/14 , 19 62 ; that (I) (we) last saw the deceased alive on 3/24 , 19 62 , and that death occurred at 10 A.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Robert A. Reiter | | | | M.D.
Robert A. Reiter, M.D. | | 22b. DATE SIGNED
4/16/62 | |
| 22c. PHYSICIAN'S NAME (Type) | | | | 22d. ADDRESS
606 Edmondson Ave. Balto - 28, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
April 17, 62 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery | | 23d. LOCATION (City, town or county) (State)
Baltimore City, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Henry W. Jenkins & Sons Co. Balt. 12, Md. | | | | 25a. RECEIVED BY REGISTRAR
APR 19 62 | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Harris | |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 8 & 9 Film G312 5/1/62 mh

04284

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Delaware
b. COUNTY Wilmington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lutherville, Md. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Wilmington | |
| c. LENGTH OF STAY IN 1b
34r-4mo | | d. STREET ADDRESS
108 Augustine Rd | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
College Manor-Seminary Ave | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Edwin Middle Byron Last Melson | | 4. DATE OF DEATH
Month April Day 22 Year 1962 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1880
May 18, 1880 |
| 9. AGE (In years last birthday)
79 | | 10. IF UNDER 1 YEAR
Months 7 Days 11 | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Bus. Exec | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
? | | 14. MOTHER'S MAIDEN NAME
? | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
222-01-1142A | |
| 17. INFORMANT
DR. WMR. MILNOR | | Address
6616 N. CHARLES ST | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) septicemia, probable
611X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) urinary tract infection - Deacidatus ulcers
DUE TO (c) chronic prostatitis | | INTERVAL BETWEEN ONSET AND DEATH
3 days
1 year | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Generalized and cerebral arteriosclerosis, severe | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. 19
p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1960 to April 22, 1962 , that (I) (we) last saw the deceased alive on April 20, 1962 , and that death occurred at 3:15 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Abraham Genecin | | 22b. DATE SIGNED
4/22/62 | |
| 22c. PHYSICIAN'S NAME (Type)
ABRAHAM GENECIN MD | | 22d. ADDRESS
714 PARK AVE BALT-1 MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
REMOVAL | | 23b. DATE THEREOF
4-24-62 | |
| 23c. NAME OF CEMETERY OR CREMATORY
RIVERVIEW | | 23d. LOCATION (City, town or county) (State)
WILMINGTON - DEL | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
WM COOK-TOWSON-1050 YORK RD | | 25a. REC'D BY REGISTRAR
4-MD | |
| ADDRESS
TOWSON | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Thomas | |
| DATE
APR 24 '62 | | | |

01281

(M)

(1)

THE COURT HAS CONSIDERED THE EVIDENCE
PRESENTED BY THE PROSECUTION AND THE
DEFENSE AND IS OF THE OPINION THAT
THE PROSECUTION HAS PROVEN BEYOND
A REASONABLE DOUBT THAT THE
DEFENDANT IS GUILTY OF THE CHARGE
OF WHICH HE IS ACCUSED. THE COURT
THEREFORE FINDS THE DEFENDANT
GUILTY OF THE CHARGE OF WHICH HE
IS ACCUSED AND SENTENCES HIM TO
THE PENITENTIARY FOR A TERM OF
FIVE YEARS.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04288

04285

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Parkville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Parkville</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>1901 E. Joppa Rd.</u> | | d. STREET ADDRESS
<u>1901 E. Joppa Rd.</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Helen</u> Middle <u>Cassandra</u> Last <u>Miller</u> | | 4. DATE OF DEATH
Month <u>April</u> Day <u>27</u> Year <u>1962</u> | |
| 5. SEX
<u>female</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>March 20, 1903</u> |
| 9. AGE (In years last birthday) <u>59</u> yrs. | | IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country)
<u>Pennsylvania</u> |
| 13. FATHER'S NAME
<u>Smith</u> | | 14. MOTHER'S MAIDEN NAME
<u>Henrietta M. Lopp</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u> </u> (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT
Name <u>John K. Miller</u> Address <u>same</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>421.4 Congestive heart failure</u>
DUE TO (b) <u>Valvular heart disease</u>
DUE TO (c) <u>Pulmonary infarct</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Hypertension.</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>28 days.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. <u> </u> p.m. <u> </u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 19, 1962</u> to <u>April 27, 1962</u> , that (I) <u>(y)</u> last saw the deceased alive on <u>April 27, 1962</u> , and that death occurred at <u>2 a.m.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Lee K Fargo</u> M.D. | | 22b. DATE SIGNED
<u>APR 30 '62</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>LEE K FARGO MD</u> | | 22d. ADDRESS
<u>8155 LOCH RAVEN BLVD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>burial</u> | 23b. DATE THEREOF
<u>4-30-62</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Loudon Park Cemetery</u> | 23d. LOCATION (City, town or county) (State)
<u>Baltimore, Md.</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>L. J. Ruck Inc.</u> | | 25a. REC'D BY REGISTRAR
<u>Arthur S. Kline</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>5305 Harford Road</u> | | DATE
<u>APR 30 '62</u> | |

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04286

04289

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Glen Arm. | | c. LENGTH OF STAY IN 1b
4 YEARS. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
LONG GREEN PIKE, | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First HELEN Middle CASSANDRA Last MONKS | | 4. DATE OF DEATH
Month APRIL Day 30 Year 1962 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
JUNE 23, 1903 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSE-WIFE | | 10b. KIND OF BUSINESS OR INDUSTRY
HOUSEKEEPER | 9. AGE (In years last birthday)
58 yrs. |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
THOMAS JACKSON MONKS | | 14. MOTHER'S MAIDEN NAME
ANNIE AMANDA MIDDENDORF | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
NONE | |
| 17. INFORMANT
MR JOHNE MONKS SR | | Address LONG GREEN PIKE GLEN ARM, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY ARTERY DISEASE.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ARTERIO-SCLEROTIC HEART DISEASE.
DUE TO
(c) DIABETES MELLITUS. | | | INTERVAL BETWEEN ONSET AND DEATH
APPROX. 7 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from OCTOBER 12, 1961 , to DECEMBER 18, 1961 , that I last saw the deceased alive on DECEMBER 18, 1961 , and that death occurred at 8:04 M., from the causes and on the date stated above.
ADDRESS (Street, city or town, state) PHOENIX, Maryland
DATE SIGNED 4-30-62 | | | |
| ACTUAL SIGNATURE Henry L. McCorkle | | M.D. JARRETTVILLE PIKE | |
| PHYSICIAN'S NAME (Type) HENRY L. MCCORKLE MD | | Phoenix, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
MAY 2, 1962 | 22c. NAME OF CEMETERY OR CREMATORY
Mt. Taber Methodist Cem. | 22d. LOCATION (City, town, or county) (State)
Rural Bel Air, Harford Co., Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Joseph W. Foster | | 24a. REC'D BY REGISTRAR
DATE MAY 2 '62 | 24b. REGISTRAR'S SIGNATURE
Arthur L. Foster |

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

(M)

| | | |
|---------------------|-----------------------|------------------------|
| NAME OF DECEASED | DATE OF DEATH | PLACE OF DEATH |
| JOHN J. JONES | 1912 | HOME |
| AGE | SEX | RACE |
| 65 | M | W |
| DATE OF BIRTH | PLACE OF BIRTH | CITY OF BIRTH |
| 1847 | MD | BALTIMORE |
| EDUCATION | RELIGION | PREVIOUS OCCUPATION |
| High School | Methodist | Teacher |
| CAUSE OF DEATH | IMMEDIATE CAUSE | UNDERLYING CAUSE |
| Heart Disease | Myocardial Infarction | Arteriosclerosis |
| DATE OF EXAMINATION | BY WHOM EXAMINED | SIGNATURE OF PHYSICIAN |
| 1912 | Dr. J. J. Jones | Dr. J. J. Jones |
| DATE OF INTERMENT | PLACE OF INTERMENT | NAME OF CEMETERY |
| 1912 | Home | Home |

Reg. Dist. No. 04287

CERTIFICATE OF DEATH

Reg. Dist. No. 04287

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland | | b. COUNTY
Baltimore City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
1 yr. 10 mo. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore City | | 3v01.4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
Summit Nursing Home, Smithwood Ave. | | d. STREET ADDRESS
3312 Hayward Ave. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
Charles W. Mooney | | First Middle Last | | 4. DATE OF DEATH
April 26, 1962 | | Month Day Year
19 | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
April 28, 1874 | |
| 9. AGE (In years last birthday)
87 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Deputy, in Peoples' Court of Balto. City | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Solomon's Island, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Marion Virginia Garner | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mr. George W. Mooney, 3312 Hayward Ave, Balto. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Mesenteric Thrombosis
453.3 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis
DUE TO
(c) Peripheral Vascular Disease | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4/25/62 to 4/26/62 , that I last saw the deceased alive on 4/25/62 , and that death occurred at 3:55 P.M. from the causes and on the date stated above. | | ADDRESS (Street, city or town, state)
1303 Frederick Road | | DATE SIGNED
4/27/62 | | | |
| ACTUAL SIGNATURE
W. E. McGrath, M.D. | | M.D. | | | | | |
| PHYSICIAN'S NAME (Type)
W. E. McGrath, M.D. | | Catonsville, Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
4/30/62 | | 22c. NAME OF CEMETERY OR CREMATORY
Cathedral Cemetery | | 22d. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
G. Vernon Lemmon | | ADDRESS
4611 Park Heights, Balto. | | 24a. REC'D BY REGISTRAR
DATE APR 30 '62 | | 24b. REGISTRAR'S SIGNATURE
Arthur E. Kruse | |

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

1920

| | | | |
|--|--|-----------------------------------|--|
| Name of Deceased
Dennis Joseph Ryan, Baltimore Ave. | | Sex
Male | |
| Age
32 | | Date of Birth
April 12, 1888 | |
| Place of Birth
Baltimore, Md. | | Usual Residence
Baltimore, Md. | |
| Cause of Death
Pneumonia | | Date of Death
April 12, 1920 | |
| Place of Death
Home | | Physician
Dr. J. H. Jones | |
| Signature of Physician | | Signature of Registrar | |
| Official Seal | | Official Seal | |

TO HOSPITAL death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04231

CERTIFICATE OF DEATH

04238

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE Maryland b. COUNTY - | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. LENGTH OF STAY IN 1b
2 Days | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Veterans Administration Hospital | | d. STREET ADDRESS
521 West 27th Street | |
| 3. NAME OF DECEASED (Type or print)
First GEORGE Middle -- Last MOONEY | | 4. DATE OF DEATH
Month April Day 4 Year 19 62 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 16, 1893 |
| 9. AGE (In years last birthday)
68 yrs. | | IF UNDER 1 YEAR
Months - Days - Hours - Min. - | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Stone Mason | | 10b. KIND OF BUSINESS OR INDUSTRY
Construction | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Mooney | | 14. MOTHER'S MAIDEN NAME
Agnes Redmon | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)
Yes WW-1 | | 16. SOCIAL SECURITY NO.
217-05-8966 | |
| 17. INFORMANT
Clin Rec VAH Fort Howard Maryland | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e) ARTERIOSCLEROTIC HEART DISEASE
DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.
DUE TO
Pneumonia Left Lung; Laennec's Cirrhosis | | INTERVAL BETWEEN ONSET AND DEATH
YEARS | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that X (this hospital) attended the deceased from April 2, 1962 , to April 4, 1962 , that X (we) last saw the deceased alive on April 4, 1962 , and that death occurred at 2:00 A.M. from the causes and on the date stated above. | | 22b. DATE SIGNED
4/4/62 | |
| 22a. SIGNATURE
Irving Freeman | | 22c. PHYSICIAN'S NAME (Type)
IRVING FREEMAN, M.D. Chief, Medical Service VAH Ft Howard, Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/6/62 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cemetery | | 23d. LOCATION (City, town or county) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Wm-Cook Blight Inc | | 25a. REC'D BY REGISTRAR
APR 9 '62 | |
| ADDRESS
6009 Harford Rd Balto Md | | 25b. REGISTRAR'S SIGNATURE
Arthur S. H. ... | |

12540

4

④. ⑤. ⑥.

E. J. M. van der Wal

62

1

• • •

1004 • J. Neurosci., September 24, 2008 • 28(39):1000–1008

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

10-1-1

1997

2544

TO HOSPITAL death. Page 4 may be retained by the hospital or attending physician. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04292

CERTIFICATE OF DEATH

04289

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Rural- Randallstown | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Rural- Randallstown | |
| c. LENGTH OF STAY IN it | | d. STREET ADDRESS
3608 Blackstone Road | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
3608 Blackstone Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) Mrs. Marguerite J. Morgan | | 4. DATE OF DEATH
April 15 19 62 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
December 13, 1898 |
| 9. AGE (In years last birthday)
63 yrs. | | 10. IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
None | |
| 11. BIRTHPLACE (County & State, or foreign country)
Augusta, Georgia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
George Greene | | 14. MOTHER'S MAIDEN NAME
Christine Roesel | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Mr. Paul T. Morgan, Sr., | | Address
3608 Blackstone Rd. Randallstown, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial failure
DUE TO Extreme cachexia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. metastatic carcinoma secondary to Ovarian CA.
DUE TO (b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (the undersigned) attended the deceased from 3/12/62 , 19 62 , to 4/14/62 , 19 62 , that (I) (we) last saw the deceased alive on 4/14/62 , 19 62 , and that death occurred at 7:30 A.M. , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
John J. Darrell | | 22b. DATE SIGNED
4/16/62 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. John J. Darrell | | 22d. ADDRESS
9017 Liberty Road, Randallstown, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4-18-62 | |
| 23c. NAME OF CEMETERY OR CREMATORY
8728 Liberty Road Randallstown, Md. | | 23d. LOCATION (City, town or county) (State)
Augusta, Georgia | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Long Byers | | 25a. REC'D BY REGISTRAR
DATE APR 19 '62 | |
| | | 25b. REGISTRAR'S SIGNATURE
William S. Kline | |

01583

CERTIFICATE OF DEATH

01583

1

100-100000-100000

100-100000-100000

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04293 CERTIFICATE OF DEATH 04290

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | | | | c. LENGTH OF STAY IN 1b
<u>X</u> <u>Towson</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>2305 Pott Spring Road</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
<u>John V. H. Murray</u> | | | | 4. DATE OF DEATH
Month <u>April</u> Day <u>8</u> Year <u>19 62</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Aug 21, 1894</u> | |
| 9. AGE (In years last birthday)
<u>67</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>ROBERT E. MURRAY</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>HORN</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>(Yes, no, or unknown)</u> | | | | 16. SOCIAL SECURITY NO. <u>(If give war or dates of service)</u> | | | |
| 17. INFORMANT
<u>Mildred N. Murray</u> | | | | Address <u>SAME</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma Stomach + Liver</u>
15 <u>15</u> DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(a), stating the underlying cause last. DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour <u>e.m.</u> Month, Day, Year <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>March 15, 1962</u> to <u>April 8, 1962</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>April 8, 1962</u> , and that death occurred at <u>5A</u> AM, from the causes and on the date stated above. | | | | | | | |
| 22e. SIGNATURE
<u>Laurence C. Post</u> | | | | 22f. ADDRESS
<u>6805 York Road</u> | | 22b. DATE SIGNED
<u>4/8/62</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Laurence C. Post</u> | | | | 22d. ADDRESS
<u>6805 York Road</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>4/10/62</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>BALTIMORE NAT'L</u> | | 23d. LOCATION (City, town or county) (State)
<u>BALTIMORE MD.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Leonard J. Ruck, Inc</u> | | | | ADDRESS
<u>5305 Harford Rd.</u> | | 25a. REC'D BY REGISTRAR
<u>APR 10 '62</u> | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kneass</u> | |

04230

04230

(M)

Robert E. Murrin
Retired
John R. Murrin
and
William H. Murrin
Caroline Murrin & Sons

March 24
Office
H/er

James D. Lee
Office

March 24
Office
H/er

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
04294

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04291

| | | | |
|---|------------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
X Catonsville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
18 Melrose Ave | | d. STREET ADDRESS
18 Melrose Ave. | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First JULIA Middle NARL Last | | 4. DATE OF DEATH
Month April Day 9 Year 1962 19 | |
| 5. SEX
Female | 6. COLOR OR RACE
Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan. 1, 1879 |
| 9. AGE (In years lost birthday)
83 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
At Home | | 10b. KIND OF BUSINESS OR INDUSTRY
Charlotteville, Va. | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Mary Price | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Mrs. Julia Brown, 1308 French St. Wilmington, Del. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
442X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) Hypertensive Cardio-Renal Disease 6 yrs. 3 mo. 6 days
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
10 Days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan. 3rd 1956 to Apr. 9th 1962 , that (I) (we) last saw the deceased alive on Apr. 9th 1962 , and that death occurred at II M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
C.F. Maloney M.D. | | 22b. DATE SIGNED
Apr. 10th 62 | |
| 22c. PHYSICIAN'S NAME (Type)
C.F. Maloney, M.D. | | 22d. ADDRESS
57 Winters Lane - Catonsville, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4-12-1962 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Western Star | | 23d. LOCATION (City, town, or county) (State)
Catonsville, Md | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
F.C. Higinbotham, Ellicott City, Md | | 25a. REC'D BY REGISTRAR
DATE APR 12 '62 | |
| 25b. REGISTRAR'S SIGNATURE
Charles S. Kure | | | |

04341

CERTIFICATE OF DEATH

04341

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04295

CERTIFICATE OF DEATH

04292

| | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Edgemere
c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
2526 Sycamore Avenue | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Edgemere
d. STREET ADDRESS
2526 Sycamore Avenue
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
First Luther Middle Last Owens | | 4. DATE OF DEATH
Month April Day 13 Year 1962 | | 5. SEX
Male | | 6. COLOR OR RACE
Colored | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
August 14, 1900 | | 9. AGE (In years last birthday) 61 yrs.
IF UNDER 1 YEAR: Months Days Hours Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Steel Worker | | 10b. KIND OF BUSINESS OR INDUSTRY
Steel Mill | | 11. BIRTHPLACE (County & State, or foreign country)
Augusta, Georgia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Owens | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes give war or dates of service) WW I | | | | 16. SOCIAL SECURITY NO.
WW I | | | | 17. INFORMANT
Address Luther Owens, Jr. - 2526 Sycamore Avenue | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction
DUE TO (b) Hypertensive Cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
10 minutes
20 years | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | | | | | | | | | | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 8-23 , 1962 to April 13, 1962 , that (I) (we) last saw the deceased alive on April 13, 1962 , and that death occurred at 10:45 AM , from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE John V. Conway, M.D. 22b. DATE SIGNED 4-13-62
22c. PHYSICIAN'S NAME (Type) John V. Conway, M.D. 22d. ADDRESS 914 D STREET BALTO. 19, Md.
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE THEREOF
4-17-62 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National | | | | 23d. LOCATION (City, town or county) (State)
Baltimore, Maryland | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Charles R. Law 802 Madison Ave., Balto., Md. | | | | | | 25a. REC'D BY REGISTRAR
APR 17 '62 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kline | | | | | | | | | | | | | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

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01232

Baltimore

Baltimore

Baltimore

Baltimore

2526 Spawson Avenue

2526 Spawson Avenue

Further

Owens

Colored

Male

Steel Worker

Steel Mill

Annata, Georgia

Union

John Owens

WM I

Yes

Further Owens, Jr. - 2526 Spawson Avenue

John Owens, Jr. - 2526 Spawson Avenue

4-27-62

Baltimore National

Baltimore, Maryland

Charles E. Law 802 Madison Ave., Balto., Md.

04296

CERTIFICATE OF DEATH

Reg. Dist. No. 4293

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
o. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Md. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 3v01-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Forest Haven Nursing Home | | d. STREET ADDRESS
405 E. Hamburg St. | |
| 3. NAME OF DECEASED (Type or print)
First MYRTLE Middle B. Last PEPERSACK | | 4. DATE OF DEATH
Month April Day 4 Year 19 62 | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3/22/1886 |
| 9. AGE (In years last birthday)
76 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
- | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
George B. North | | 14. MOTHER'S MAIDEN NAME
Marclena Ozmon | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
-- | | 16. SOCIAL SECURITY NO.
-- | |
| 17. INFORMANT
Francis J. Pepersack | | Address
7318 Yorktown Dr. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE - PULMONARY EDEMA
DUE TO DIASTOLIC HYPERTENSION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 7/1 , 19 61 , to 4/4 , 19 62 , that I last saw the deceased alive on 4/4 , 19 62 , and that death occurred at 3 A M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
John F. Denny, Inc. Baltimore, Md. 4/6/62 | | | |
| ACTUAL SIGNATURE
John F. Denny, Inc. M.D. Edmund S. Davis | | PHYSICIAN'S NAME (Type)
John F. Denny, Inc. Baltimore, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
4/7/62 | 22c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer | 22d. LOCATION (City, town, or county) (State)
Baltimore, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
JOHN F. DENNY, INC. 715 Light St. | | 24a. REC'D BY REGISTRAR
DATE APR 10 '62 | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hume |

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-peppers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED
JOHN W. DUNN, JR. | | 2. SEX
Male | | 3. AGE
45 | | 4. DATE OF BIRTH
1910 | | 5. PLACE OF BIRTH
BALTIMORE, MARYLAND | |
| 6. OCCUPATION
Salesman | | 7. MARITAL STATUS
Married | | 8. EDUCATION
High School | | 9. RELIGION
Roman Catholic | | 10. RACE
White | |
| 11. CAUSE OF DEATH
Heart Disease | | 12. MANNER OF DEATH
Natural | | 13. DATE OF DEATH
1955 | | 14. PLACE OF DEATH
Home | | 15. SIGNATURE OF DECEASED
(None) | |
| 16. SIGNATURE OF NEXT OF KIN
Mary W. Dunn | | 17. SIGNATURE OF PHYSICIAN
Dr. J. H. Smith | | 18. SIGNATURE OF CLERK
John A. Jones | | 19. SIGNATURE OF REGISTRAR
John B. Brown | | 20. SIGNATURE OF WITNESS
John C. Green | |



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--------------------------------|--|---|--|---|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 04297 | | | | | | | | | | | |
| 04294 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Balto. | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Md b. COUNTY Balto | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
White Marsh | | | | c. LENGTH OF STAY IN 1b
10 yrs | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X White Marsh | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Box 1072 Beach Avenue | | | | | | | | d. STREET ADDRESS
Box 1027 Beach Avenue | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Charles Pilkington | | | | 4. DATE OF DEATH
Month Day Year
4 18 1962 | | | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
8-12-1877 | | 9. AGE (In years last birthday)
84 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Silver Smith | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Gorham Co | | 11. BIRTHPLACE (County & State, or foreign country)
England | | | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 13. FATHER'S NAME
Samuel Pilkington | | | | 14. MOTHER'S MAIDEN NAME
Emma King | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give year or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
037-05-0026 | | 17. INFORMANT
Address
Mrs Olive L. Bragg Box 1027 Beach Avenue | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Severe Myocardial Ischemia
293X DUE TO Auto immune hemolytic disease, chronic
(b) progressive anemia
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic urinary retention due to prostatic enlargement | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 wks.
several yrs. | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m.
19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Mar. 28, 1959 to Apr. 18, 1962 that (I) (we) last saw the deceased alive on April 7, 1962, and that death occurred at 8:30 A.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
 | | | | M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
4/19/62 | | | |
| 22c. PHYSICIAN'S NAME (Type)
Theodore E. Evans, M.D. | | | | 22d. ADDRESS
9660 Belair Rd. -36-Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4-21-1962 | | 23c. NAME OF CEMETERY OR CREMATORY
St John's Epic. Cemetery | | | | 23d. LOCATION (City, town or county) (State)
Kingsville Md. | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Lassan Funeral Home 7401 Belair Road | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR
DATE APR 23 '62 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Evans | |

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TO HOSPITAL
TO FUNERAL DIRECTOR:
The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04298

CERTIFICATE OF DEATH

04295

| | | | | | | | |
|--|----------------------------------|--|--|--|---|--|--------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE Maryland b. COUNTY ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN Ib
38yr8mth29dys | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 3 v 01-4 | | d. STREET ADDRESS
1507 North Durham Street | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | | | a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
Adolph Henry Plitt | | First Middle Last | | 4. DATE OF DEATH
April 26 19 62 | | Month Day Year | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 17, 1900 | | 9. AGE (In years last birthday)
62 yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
clerk | | | 10b. KIND OF BUSINESS OR INDUSTRY
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | | |
| 13. FATHER'S NAME
unknown Henry Plitt | | | 14. MOTHER'S MAIDEN NAME
unknown Bertha Schultze | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
unknown | | | 16. SOCIAL SECURITY NO.
unknown | | 17. INFORMANT
Address
Records: SPRING GROVE STATE HOSPITAL | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e) Bilateral pneumonia
490X DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY
Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that to (this hospital) attended the deceased from July 21 19 62 to April 26 19 62 , that (I) was last saw the deceased alive on April 26 19 62 , and that death occurred at 3:00 P. M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Stella Wachslar M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
4-26-62 | |
| 22c. PHYSICIAN'S NAME (Type)
Stella Wachslar, M. D. | | | | 22d. ADDRESS
SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
April 28, 1962 | | 23c. NAME OF CEMETERY OR CREMATORY
London Park Cem. | | 23d. LOCATION (City, town or county) (State)
Baltimore Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Therman Schauf ADDRESS 3512 FREDERICK AVE | | | | 25a. REC'D BY REGISTRAR
APR 30 '62 | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Hume | |

VR A15 (4)
15M 9/60

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M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04299

CERTIFICATE OF DEATH

04296

Item 9 Film G312 5/4/62 iwk

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills
c. LENGTH OF STAY IN TB 3 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Training School
5625 Wayne Avenue | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) <input checked="" type="checkbox"/>
a. STATE Maryland b. COUNTY -
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS 5625 Wayne Avenue
e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 3. NAME OF DECEASED (Type or print) William H. PLUMMER
First Middle Last
5. SEX Male 6. COLOR OR RACE White
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 2/20/1888
9. AGE (In years last birthday) 74 7/3 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dependent
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Henry G. Plummer
14. MOTHER'S MAIDEN NAME Ella V. Murdock
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. none
17. INFORMANT Rosewood Records, Owings Mills, Md. Address | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia
DUE TO (b) Carcinoma of bladder with invasion, muscular and left ureters
DUE TO (c) Nephro-sclerosis, senile
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Mental retardation with behavioral reaction, idiopathic. Hemaplegia, upper right
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 11/10
Hour a.m. 1:58 p.m. 1962
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 11/10
20f. (City or town) 1958 (County) 4/24 (State) 1962
21. I certify that (H) (this hospital) attended the deceased from 11/10 1958 to 4/24 1962 that (H) (we) last saw the deceased alive on 4/24 1962 and that death occurred at 1:58 p.m. the causes and on the date stated above. | | | | 22a. SIGNATURE Harry G. Butler M.D.
22c. PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.
22b. DATE SIGNED April 24, 1962
22d. ADDRESS Rosewood Lane, Owings Mills, Maryland
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF 4/27/62
23c. NAME OF CEMETERY OR CREMATORY New CATHEDRAL BALTIMORE Md.
23d. LOCATION (City, town or county) BALTIMORE (State) Md.
24. FUNERAL DIRECTOR'S SIGNATURE Ed Ruck Inc ADDRESS 5305 Hanford Road
25a. REC'D BY REGISTRAR DATE APR 30 '62
25b. REGISTRAR'S SIGNATURE Arthur L. Harris | | | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

04510



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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

| <div>Item 18 File 314 6/4/62</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>04300</div> <div>04297</div> | | | | | | | | | | | |
|---|--|------------------|--|---|--|--|--|---|--|------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY | | | | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | | | c. LENGTH OF STAY in 1b | | | |
| Baltimore | | | | Catonsville | | | | 5 Months 4 days | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | e. STREET ADDRESS | | | | f. IS RESIDENCE ON A FARM? | | | |
| Spring Grove State Hospital | | | | 1124 W. Pratt Street | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | | | 4. DATE OF DEATH | | | | 5. IS RESIDENCE ON A FARM? | | | |
| Albert D. Pocklington, Sr. | | | | April 7, 1962 | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. IF UNDER 24 HRS. | |
| Male | | White | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | August 4, 1917 | | 11 yrs. | | Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) | | | |
| PIPE COVERER | | | | CONT | | | | BALTO Md | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | |
| ALBERT D. Pocklington | | | | Margaret Hopwood | | | | No | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | |
| XRO-01-1471 | | | | Christina O. Pocklington | | | | PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia with abscess formation
025X DUE TO General paresis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1B.) | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20c. TIME OF INJURY | | Month, Day, Year | | 20d. INJURY OCCURRED | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) (State) | |
| Hour a.m. p.m. | | 19 | | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | M.D. | | | | DATE SIGNED | | | |
| R. Breiteneker | | | | | | | | April 8, 1962 | | | |
| EXAMINER'S NAME (Type) | | | | Address (Street, city, town, or county) | | | | 22a. BURIAL, CREMATION, REMOVAL (Specify) | | | |
| R. Breiteneker, M. D. | | | | | | | | 22b. DATE THEREOF | | | |
| | | | | | | | | 22c. NAME OF CEMETERY OR CREMATORY | | | |
| | | | | | | | | 22d. LOCATION (City, town, or county) (State) | | | |
| | | | | | | | | 23. FUNERAL DIRECTOR | | | |
| | | | | | | | | 24a. REC'D BY REGISTRAR | | | |
| | | | | | | | | 24b. REGISTRAR'S SIGNATURE | | | |
| | | | | | | | | DATE | | | |
| | | | | | | | | APR 10 '62 | | | |
| | | | | | | | | Arthur S. Hume | | | |

041337

2000



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 12 & 14 Film G312 5/1/62 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

04298

04301

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD b. COUNTY BALTO. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | | | | c. LENGTH OF STAY IN 1b 40 yrs | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7500 DURWOOD RD. | | | | d. STREET ADDRESS 7500 DURWOOD RD. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First ANTHONY Middle A Last PODLES | | | | 4. DATE OF DEATH Month 4 Day 24 Year 1962 | | | |
| 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 2/14/16 | |
| 9. AGE (In years last birthday) 46 yrs. | | IF UNDER 1 YEAR Months 4 Days 24 Hours 19 Min. | | IF UNDER 24 HRS. Months 4 Days 24 Hours 19 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GLAZER | | | | 10b. KIND OF BUSINESS OR INDUSTRY CAPLAN GLASS CO. | | | |
| 11. BIRTHPLACE (State or foreign country) PAST CHRISTIAN MISS. | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME JACOB Podles | | | | 14. MOTHER'S MAIDEN NAME KATHERINE unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 220-07-9045 | | | |
| 17. INFORMANT ANGELA PODLES Address 7500 DURWOOD RD. | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Mesothelioma Peritoneum
230 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 230 DUE TO
(c) 230 DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Embolism - Histoplasmosis
INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from Nov. , 1961, to March , 1962, that I last saw the deceased alive on March 13 , 1962, and that death occurred at 4 A.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 7840 Eastern Ave - DATE SIGNED Boat 24, Md. | | | | | | | |
| ACTUAL SIGNATURE Manuel P. de Leon M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) MANUEL P. DE LEON | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | 22b. DATE THEREOF 4/28/62 | | | |
| 22c. NAME OF CEMETERY OR CREMATORY SACRED HEART OF MARY | | | | 22d. LOCATION (City, town, or county) (State) BALTO. MD | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Walter Nakowski ADDRESS 1005 DUNDALK AVE. | | | | 24a. REC'D BY REGISTRAR APR 26 '62 | | | |
| 24b. REGISTRAR'S SIGNATURE Boat 24, Md. | | | | | | | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04302 CERTIFICATE OF DEATH 04299

| | | | |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. LENGTH OF STAY IN 1b
3 Days | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Veterans Administration Hospital | | d. STREET ADDRESS
9001 Liberty Road | |
| 3. NAME OF DECEASED
(Type or print)
JOHN P. RAINEY, SR. | | 4. DATE OF DEATH
Month APRIL Day 8 Year 1962 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3/17/93 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Shipping Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY
Iron Foundry | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Rainey | | 14. MOTHER'S MAIDEN NAME
Mary Connelly | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WW I | | 16. SOCIAL SECURITY NO.
216-07-1558 | |
| 17. INFORMANT
Clin. Rec. VAH, Fort Howard, Maryland | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CIRRHOSIS OF LIVER
581.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC USE OF ALCOHOL
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
UNKNOWN
UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
MALNUTRITION. PEPTIC ULCER | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from April 5, 1962 to April 8, 1962 , that (I) (we) last saw the deceased alive on April 8, 1962 , and that death occurred at 2:15 AM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Daniel R. Zoll M.D. | | 22b. DATE SIGNED
4/8/62 | |
| 22c. PHYSICIAN'S NAME (Type)
DANIEL R. ZOLL, M.D. | | 22d. ADDRESS
VA HOSPITAL, FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/11/62 | |
| 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery | | 23d. LOCATION (City, town or county) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Ellsworth Armacost | | 25a. REC'D BY REGISTRAR
APR 9 '62 | |
| ADDRESS
Ellsworth Armacost Funeral Chapel, Balto. Md. | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Hanks | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | |
|---|----------------------------------|---|--|
| 04303 | | 04300 | |
| 1. PLACE OF DEATH
a. COUNTY <i>Baltimore</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<i>Dundalk</i> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<i>Dundalk</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<i>1227 Willow Road</i> | | d. STREET ADDRESS
<i>1227 Willow Road</i> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<i>Owen E. Ramey</i> | | 4. DATE OF DEATH
Month Day Year
<i>4 29 19 62</i> | |
| 5. SEX
<i>male</i> | 6. COLOR OR RACE
<i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>6-12-1922</i> |
| 9. AGE (In years last birthday)
<i>39</i> yrs. | | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>(conductor)(freight)</i> | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>Penna. R. R.</i> | 11. BIRTHPLACE (County & State, or foreign country)
<i>Maryland</i> |
| 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | |
| 13. FATHER'S NAME
<i>Daniel Ramey</i> | | 14. MOTHER'S MAIDEN NAME
<i>Grace Ann Frye</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<i>yes</i> | | 16. SOCIAL SECURITY NO.
<i>218161299</i> | |
| 17. INFORMANT
<i>Rosalie G. Ramey</i> | | Address
<i>same</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Pneumonia</i>
434.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Congestive Heart Failure</i>
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
<i>4 days</i>
<i>8 years</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<i>081X</i> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<i>Bulbar Polio (1950)</i> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <i>19</i> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (the hospital) attended the deceased from <i>4/26</i> , 19 <i>62</i> to <i>4/29</i> , 19 <i>62</i> that (I) (<i>we</i>) last saw the deceased alive on <i>4/29</i> , 19 <i>62</i> and that death occurred at <i>4:45</i> A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Ronald E. Keyser, M.D.</i> | | 22b. DATE SIGNED
<i>30 APRIL 1962</i> | |
| 22c. PHYSICIAN'S NAME (Type)
<i>RONALD E. KEYSER, M.D.</i> | | 22d. ADDRESS
<i>4016 WOODRIDGE RD. BALTO. 29 MD.</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>burial</i> | | 23b. DATE THEREOF
<i>5-2-62</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<i>Belair Mem. Gardens</i> | | 23d. LOCATION (City, town or county) (State)
<i>Belair, Md.</i> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>L.J. Ruck Inc.</i> | | 25a. REC'D BY REGISTRAR
<i>MAY 4 '62</i> | |
| ADDRESS
<i>5305 Harford Rd.</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Arthur S. Frame</i> | |

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04301

| | | | |
|--|-------------------------------|--|------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville
c. LENGTH OF STAY IN lb 22 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE Maryland
f. COUNTY -
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS 1011 Letitia Avenue
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) Anna . ONA- Razgaitis | | 4. DATE OF DEATH
April 15 1962 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1876 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown Tailor (Cont. Maker) | | 11. BIRTHPLACE (County & State, or foreign country) LITHUANIA | |
| 13. FATHER'S NAME unknown | | 14. MOTHER'S MAIDEN NAME unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown | | 16. SOCIAL SECURITY NO. 215-435707 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL
Address _____
INTERVAL BETWEEN ONSET AND DEATH _____ | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 23, 1962 to April 15, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 15, 1962 , and that death occurred at 5:20 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Stella Wachslar M.D. | | 22b. DATE SIGNED 4-16-62 | |
| 22c. PHYSICIAN'S NAME (Type) Stella Wachslar M. D. | | 22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 4/18/62 | |
| 23c. NAME OF CEMETERY OR CREMATORY Holy REDEEMER | | 23d. LOCATION (City, town or county) Belair Rd - Md. (State) _____ | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Charles W. Fachanston | | 25a. REC'D BY REGISTRAR APR 18 '62 | |
| ADDRESS 637 Wash. Blvd. | | 25b. REGISTRAR'S SIGNATURE Arthur S. Hanna | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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7072-27-215

- 17 points - 10/10/19 - 10/10/19

TO HOSPITAL death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

hours after death

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04302

| | | | |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MD. b. COUNTY - | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
CATONSVILLE | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
BALTO. | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
RIDGEWAY MANOR CONVALESCENT HOME | | d. STREET ADDRESS
4736 FREDERICK AVE. | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
MARY W. REA | | 4. DATE OF DEATH
Month Day Year
APR. 21, 1962 | |
| 5. SEX
F. | 6. COLOR OR RACE
W. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
FEB. 4, 1880 |
| 9. AGE (In years last birthday)
82 yrs. | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
H.W. | | 10b. KIND OF BUSINESS OR INDUSTRY
O.H. | |
| 11. BIRTHPLACE (County & State, or foreign country)
MD. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JAMES R. WHOLEY | | 14. MOTHER'S MAIDEN NAME
ELIZABETH PEASTER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
MR. JOSEPH B. REA (SON)
4736 FREDERICK AVE, BALTO, 29, MD. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
DUE TO
Conditions, if any, which gave rise to immediate cause (b) Hypertensive Cerebro Vascular Disease
(c), stating the underlying cause last. Cerebral Thrombosis | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH
4/14/62
5 years | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year
Hour e.m. p.m. 19 | |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from 4/19 to 4/21 , 19 62 , that (I) (we) last saw the deceased alive on 4/19 , 19 62 , and that death occurred at 4/21 , from the causes and on the date stated above. | |
| 22a. SIGNATURE
Eliot W. Johnson | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS
3432 Frederick Ave. Baltimore 29 Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
4/24/62 | |
| 23c. NAME OF CEMETERY OR CREMATORY
DRUID RIDGE | | 23d. LOCATION (City, town or county) (State)
PIKESVILLE MD. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
WITZKE, 4101 EDMONDSON AVE. | | 25a. REC'D BY REGISTRAR
DATE APR 26 '62 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur L. Hanna | | | |

01308

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[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Baptism" and "Baptized" are faintly visible.]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within _____ hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04306

CERTIFICATE OF DEATH

04303

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Howard | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. LENGTH OF STAY IN TB
9 Days | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Veterans Administration Hospital | | e. STREET ADDRESS
Ridge Road | |
| 3. NAME OF DECEASED
(Type or print)
RAYMOND S. REID | | 4. DATE OF DEATH
Month APRIL Day 25TH Year 1962 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1/22/95 |
| 9. AGE (In years last birthday) 67 yrs. | | 10. AGE (If UNDER 1 YEAR) Months 25TH Days 19 Hours 62 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY
Insurance | |
| 11. BIRTHPLACE (County & State, or foreign country)
Newport, Kentucky | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Samuel Reid | | 14. MOTHER'S MAIDEN NAME
Elizabeth Elliott | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WW I | | 16. SOCIAL SECURITY NO.
235-12-5809 | |
| 17. INFORMANT
Clin.Rec. VAH, Fort Howard, Maryland | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
DUE TO HYPERTENSIVE AND ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
? MINUTES
UNDET. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Hypertrophy of Prostate | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 16, 1962 to April 25, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 25, 1962 , and that death occurred at 7:50 AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
 | | 22b. DATE SIGNED
4/25/62 | |
| 22c. PHYSICIAN'S NAME (Type)
IRVING FREEMAN, M.D. | | 22d. ADDRESS
VAH, FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
4-27-62 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National | | 23d. LOCATION (City, town or county) (State)
Baltimore | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Wm. Cook-Blight, 6009 Harford Road, Baltimore 14 | | 25a. REC'D BY REGISTRAR
APR 27 '62 | |
| 25b. REGISTRAR'S SIGNATURE
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04307

CERTIFICATE OF DEATH

Reg. Dist. No.

04304

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|---|-----------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural: Towson | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 9 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Eudowood Sanatorium
Towson 4, Maryland | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
THOMAS N. RIDGAWAY | | 4. DATE OF DEATH
Month Day Year
April 12 1962 | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Month Day Year
Nov 7 1897 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY
Md. Baltimore Co. | |
| 11. BIRTHPLACE (State or foreign country)
U.S.A. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Howard H Ridgaway | | 14. MOTHER'S MAIDEN NAME
Carrie Wood | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
216-03-546 | |
| 17. INFORMANT
Personal History & Hospital Records, Eudowood Sanatorium | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
a) Bronchogenic Carcinoma, left lower lobe.
b) Left ventricular failure with pulmonary oedema due to marked pulmonary emphysema.
c) Left ventricular failure with pulmonary oedema due to marked pulmonary emphysema. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Left ventricular failure with pulmonary oedema due to marked pulmonary emphysema. | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I of Part II of item 18.) | |
| 20c. TIME OF INJURY
Month Day Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 4, 1961 to April 12, 1961, that I last saw the deceased alive on April 6, 1962, and that death occurred at 6:50 A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state)
DATE SIGNED
Milton B. Kress, M. D.
Eudowood Sanatorium
Towson 4, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
4-14-62 | |
| 22c. NAME OF CEMETERY OR CREMATORY
DRUID RIDGE | | 22d. LOCATION (City, town, or county) (State)
PIKESVILLE MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
H.W. JENKINS & SONS CO. 4905 YORK RD. | | 24a. REC'D BY REGISTRAR
DATE APR 13 '62 | |
| 24b. REGISTRAR'S SIGNATURE
Charles E. Hanna | | | |

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04305

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville c. LENGTH OF STAY IN 1b
24yr8mt1ldys
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
a. STATE Maryland b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore d. STREET ADDRESS
310 S. Broadway - Zone 31
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
Frances Roberts | | | | 4. DATE OF DEATH
April 2, 1962 | | | |
| 5. SEX
female | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Aug. 19, 1881 | |
| 9. AGE (In years last birthday)
80 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Germany | |
| 12. CITIZEN OF WHAT COUNTRY?
Germany | | 13. FATHER'S NAME
Joseph Kleis | | 14. MOTHER'S MAIDEN NAME
Mary | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
unknown | |
| 16. SOCIAL SECURITY NO.
705-09-1373 | | 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
Part I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro - Vasc. Accident
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arterioscl. Cardio Vasc. Disease
(c)
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH
1 day | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 21, 1937 to 4/2, 1962 that (I) (we) last saw the deceased alive on 4/2, 1962 and that death occurred at 325 M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Stella Wachslar M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
4/2/62 | |
| 22c. PHYSICIAN'S NAME (Type)
STELLA WACHSLER | | | | 22d. ADDRESS
SPRING GROVE STATE HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/2/62 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Rosary | | 23d. LOCATION (City, town or county) (State)
Balto. Co. Md | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Wm. S. Fialkowski | | | | 25a. REC'D BY REGISTRAR
APR 3 '62 | | 25b. REGISTRAR'S SIGNATURE
William S. Fialkowski | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04805

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TO HOSPITAL OR EXTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/60

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---------------------------|--|---|--|---|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 04309 | | | | CERTIFICATE OF DEATH | | | | 04306 | | | |
| Item 9 Film G312 5/4/62 iwk | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>BALTO.</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTO.</u>
c. LENGTH OF STAY IN 1b <u>2 M. 24 days</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE HOSP.</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>MD</u>
b. COUNTY <u>BALTO.</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTO.</u>
d. STREET ADDRESS <u>3708 CRANSTON AVE.</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>MARY BERNICE</u> | | | | 4. DATE OF DEATH <u>4</u> <u>22</u> <u>1962</u> | | | | | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>4/8/88</u> | | 9. AGE (In years last birthday) <u>74</u> yrs. | | 10. IF UNDER 1 YEAR Months Days | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES lady</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (County & State, or foreign country) <u>BALTO MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>JOSEPH ROEDER</u> | | | | 14. MOTHER'S MAIDEN NAME <u>ROSA KATHMAN</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u> | | | | 16. SOCIAL SECURITY NO. <u>216012653A</u> | | | | 17. INFORMANT <u>CARROLL R. ROEDER</u>
Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u>
<u>420.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>Generalized arteriosclerosis</u>
(a), stating the underlying cause last. DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Decubital gangrene and toxemia</u> | | | | | | | | | | | |
| 20a. TIME OF INJURY
Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21. I certify that (X) (this hospital) attended the deceased from <u>Jan. 30</u> <u>8:15</u> <u>1962</u> to <u>April 22</u> <u>1962</u> that (X) (we) last saw the deceased alive on <u>April 22</u> <u>1962</u> , and that death occurred at <u>8:15</u> <u>P.</u> <u>M.</u> from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>Stella Wachslar</u> | | | | M.D. <u>Stella Wachslar, M. D.</u> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | DATE <u>4-23-62</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) | | | | 22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u>
<u>Catonsville 28, Maryland</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | 23b. DATE THEREOF <u>4/26/62</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u> | | 23d. LOCATION (City, town or county) <u>BALTIMORE</u> | | (State) <u>MD</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Ruck Inc</u> | | | | ADDRESS <u>5305 HARTFORD Rd.</u> | | 25a. REC'D BY REGISTRAR <u>APR 30 '62</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u> | | | |



00300

Ball's

Don't leave the
Bureau

21st May
To: Mr. R. J. R. R.

21st May
R. J. R. R.

21st May
R. J. R. R.

21st May
R. J. R. R.

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R. J. R. R.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

#1

14

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | |
| 04310 Item 2 Film G311 4/24/62 mb | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 04307 | | | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | | | | | c. LENGTH OF STAY IN 1b <u>5 mo.</u> | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Spring Grove State Hospital</u> | | | | | | d. STREET ADDRESS <u>22 S. Athol St.</u> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>James Joseph Rogers</u> | | | | | | 4. DATE OF DEATH <u>4</u> <u>8</u> <u>1962</u> | | | | | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>10-7-1880</u> | | 9. AGE (In years last birthday) <u>81</u> yrs. | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>engineer</u> | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>New York</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | |
| 13. FATHER'S NAME <u>Patrick Rogers</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Mary O'Donnell</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | | | | | 16. SOCIAL SECURITY NO. <u>072-03-1767</u> | | 17. INFORMANT <u>Joseph S. Porta - Spring G. State Hosp.</u> Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>
4-20-0 DUE TO (b) <u>Arteriosclerosis, generalized</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u> | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that <u>W</u> (this hospital) attended the deceased from <u>10-20-1961</u> to <u>4-8-1962</u> that <u>W</u> (we) last saw the deceased alive on <u>4-8-1962</u> and that death occurred at <u>253</u> M. from the causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>Jose R. Arizaga, M.D.</u> | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>SPRING GROVE STATE HOSP.</u> | | | | | | 22d. ADDRESS <u>SPRING GROVE STATE HOSP.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>4-11-62</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u> | | 23d. LOCATION (City, town or county) <u>Baltimore</u> | | (State) | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Towson, Inc.,</u> ADDRESS <u>1050 York Road, TOWSON 4 Md</u> | | | | | | 25a. REC'D BY REGISTRAR <u>APR 10 '62</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hane</u> | | | | | |

VR A15 (4)
15M 9/60

(M)

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01310

Mr. Cook-In-Don, Inc., 1030 York Road, Towson and
Baltimore, Maryland

Mr. J. L. G. G. G.

Mr. J. L. G. G. G.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|---|----------------------------------|---|-------------------------------------|
| 1. NAME OF DECEASED
(Type or Print) <i>Henry J. Rommel</i> | | 2. DATE OF DEATH
<i>4-13-62</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION
<i>Baltimore County - Md
Catonsville
House In The Pines Nursing Home</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Md.</i> B. COUNTY <i>26-09</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>
D. STREET ADDRESS (If rural, give location) <i>3401-4
602 South Grundy St.</i> | |
| 5. SEX
<i>male</i> | 6. COLOR OR RACE
<i>white</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
<i>married</i> | 8. DATE OF BIRTH
<i>5-4-1885</i> |
| 9. AGE (In years last birthday)
<i>76</i> | | 10. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Ret. Watchman</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Cont. Can Co.</i> | |
| 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 13. FATHER'S NAME
<i>John August Rommel</i> | | 14. MOTHER'S MAIDEN NAME
<i>Elizabeth Sonn</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<i>Charles Rommel</i> | | ADDRESS
<i>2704 Woodsdale Ave.</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>420-1 Cerebral Thrombosis</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4/16</i> to <i>4/17</i> , that (I) (we) last saw the deceased alive on <i>4/13</i> and that in (my) (our) opinion death occurred at <i>2:48</i> p.m. from the causes and on the date stated above. | | | |
| 23A. SIGNATURE
<i>J. H. [Signature]</i> | | 23B. ADDRESS
<i>3400 E Belt W</i> | |
| 23C. DATE SIGNED
<i>4/17/62</i> | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
<i>burial</i> | | 24B. DATE
<i>4-19-62</i> | |
| 24C. NAME OF CEMETERY OR CREMATORY
<i>Oaklawn Cemetery</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>APR 17 1962</i> | | 25B. NAME OF REGISTRAR
<i>William N. [Signature]</i> | |
| 25C. FUNERAL DIRECTOR
<i>J. Ruck Inc.</i> | | ADDRESS
<i>5305 Harford Rd.</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. NAME OF THE PARTY
2. ADDRESS OF THE PARTY
3. CITY OF THE PARTY
4. STATE OF THE PARTY
5. ZIP CODE OF THE PARTY

6. DATE OF THE PARTY
7. TIME OF THE PARTY
8. PLACE OF THE PARTY
9. REASON FOR THE PARTY
10. OTHER INFORMATION

11. NAME OF THE GUEST
12. ADDRESS OF THE GUEST
13. CITY OF THE GUEST
14. STATE OF THE GUEST
15. ZIP CODE OF THE GUEST

16. DATE OF THE GUEST
17. TIME OF THE GUEST
18. PLACE OF THE GUEST
19. REASON FOR THE GUEST
20. OTHER INFORMATION

21. NAME OF THE GUEST
22. ADDRESS OF THE GUEST
23. CITY OF THE GUEST
24. STATE OF THE GUEST
25. ZIP CODE OF THE GUEST

26. DATE OF THE GUEST
27. TIME OF THE GUEST
28. PLACE OF THE GUEST
29. REASON FOR THE GUEST
30. OTHER INFORMATION

31. NAME OF THE GUEST
32. ADDRESS OF THE GUEST
33. CITY OF THE GUEST
34. STATE OF THE GUEST
35. ZIP CODE OF THE GUEST

36. DATE OF THE GUEST
37. TIME OF THE GUEST
38. PLACE OF THE GUEST
39. REASON FOR THE GUEST
40. OTHER INFORMATION

41. NAME OF THE GUEST
42. ADDRESS OF THE GUEST
43. CITY OF THE GUEST
44. STATE OF THE GUEST
45. ZIP CODE OF THE GUEST

46. DATE OF THE GUEST
47. TIME OF THE GUEST
48. PLACE OF THE GUEST
49. REASON FOR THE GUEST
50. OTHER INFORMATION

51. NAME OF THE GUEST
52. ADDRESS OF THE GUEST
53. CITY OF THE GUEST
54. STATE OF THE GUEST
55. ZIP CODE OF THE GUEST

56. DATE OF THE GUEST
57. TIME OF THE GUEST
58. PLACE OF THE GUEST
59. REASON FOR THE GUEST
60. OTHER INFORMATION

61. NAME OF THE GUEST
62. ADDRESS OF THE GUEST
63. CITY OF THE GUEST
64. STATE OF THE GUEST
65. ZIP CODE OF THE GUEST

66. DATE OF THE GUEST
67. TIME OF THE GUEST
68. PLACE OF THE GUEST
69. REASON FOR THE GUEST
70. OTHER INFORMATION

71. NAME OF THE GUEST
72. ADDRESS OF THE GUEST
73. CITY OF THE GUEST
74. STATE OF THE GUEST
75. ZIP CODE OF THE GUEST

76. DATE OF THE GUEST
77. TIME OF THE GUEST
78. PLACE OF THE GUEST
79. REASON FOR THE GUEST
80. OTHER INFORMATION

81. NAME OF THE GUEST
82. ADDRESS OF THE GUEST
83. CITY OF THE GUEST
84. STATE OF THE GUEST
85. ZIP CODE OF THE GUEST

86. DATE OF THE GUEST
87. TIME OF THE GUEST
88. PLACE OF THE GUEST
89. REASON FOR THE GUEST
90. OTHER INFORMATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | |
| 04312 | | CERTIFICATE OF DEATH | | | | | | 04309 | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Glen Arm
c. LENGTH OF STAY IN lb
MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Long Green Road | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Glen Arm
d. STREET ADDRESS
Long Green Road
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
Lillian First
Catherine Middle
Russell Last | | 4. DATE OF DEATH
April 21 1962 | | 5. SEX
F | | 6. COLOR OR RACE
W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Aug. 15 1902 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY
Baltimore County | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 9. AGE (In years last birthday)
59 yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/> | | | | | | | |
| 13. FATHER'S NAME
Arthur R. Clayton | | 14. MOTHER'S MAIDEN NAME
Lilly Dilworth | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes give year or dates of service) | | 17. INFORMANT
Elmer L. Russell, Long Green Road, Glen Arm, Md
Address | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
420.1 DUE TO AS clvd
Conditions, if any, which gave rise to immediate cause (b)
(a), stating the underlying cause last. DUE TO (c) | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
immediate | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Sept. 1961 to April, 1962 , that (I) (we) last saw the deceased alive on 4-21-1962 and that death occurred at 9:45 p.m. from the causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE
William A. Tyson | | 22b. DATE SIGNED
4-21-62 | | 22c. PHYSICIAN'S NAME (Type)
William A. Tyson, M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22d. ADDRESS
Kingsville, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
4-24-62 | | 23c. NAME OF CEMETERY OR CREMATORY
Fork Methodist Church Cemetery, | | 23d. LOCATION (City, town or county) (State)
Fork, Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
William Cook-Towson, Inc., | | ADDRESS
1050 York Rd. Towson 4 | | 25a. REC'D BY REGISTRAR
DATE APR 24 '62 | | 25b. REGISTRAR'S SIGNATURE
Wm L. Thane | | | | | | | |

01809

01812

Long Street Road

Long Street Road

Section 8. B. 1930

Section 8. B. 1930

Elmer J. Russell, Long Street Road, New York

Kingville, Maryland

Elmer J. Russell, D.

York Heights Co. (Incorporated), York, Maryland

Elmer J. Russell, Inc., 1030 York Rd., New York

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04313 CERTIFICATE OF DEATH 05543

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural- Hernwood, Randallstown | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural- Hernwood, Randallstown, Maryland | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Marriottsville Road | | d. STREET ADDRESS
Marriottsville Road
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Mrs. Frances Hunter | | 4. DATE OF DEATH
Month April Day 14 Year 19 62 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 31, 1877 |
| 9. AGE (In years last birthday)
84 yrs. | | IF UNDER 1 YEAR
Months 0 Days 0
IF UNDER 24 HRS.
Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
None | |
| 11. BIRTHPLACE (County & State, or foreign country)
Marriottsville, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Butler | | 14. MOTHER'S MAIDEN NAME
Mahala Woodward | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Miss Mary J. Saumenig, | | Address Marriottsville Road Randallstown, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Emphysema
4-22-62 DUE TO (b) Suppurative Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH 2 weeks
10 yrs | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. 19 p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Oct 22, 1957 to April 14, 1962 ; that (I) (we) last saw the deceased alive on April 13, 1962 , and that death occurred 12:15 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Edwin L. Pierpont | | 22b. DATE SIGNED
April 14, 1962 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Edwin L. Pierpont | | 22d. ADDRESS
8204 Liberty Rd., Baltimore 7, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4-17-62 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge Cemetery | | 23d. LOCATION (City, town or county) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Loring Byers | | 25a. REC'D BY REGISTRAR
APR 19 62
DATE | |
| 25b. REGISTRAR'S SIGNATURE
Arthur L. ... | | | |

00313

00343

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John S. Siler

John S. Siler

[Faint, mostly illegible text covering the majority of the page, likely bleed-through from the reverse side. Some words like "John S. Siler" are visible.]

CERTIFICATE OF DEATH

Reg. Dist. No. 04310

04314

| | | | |
|--|-------------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Timonium | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Timonium | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
223 Falls Brook Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First ANNA Middle VERONICA Last SCHAEFFER | | 4. DATE OF DEATH
Month April Day 10 Year 19 62 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8/31/84 |
| 9. AGE (In years last birthday)
77 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Saleslady | | 10b. KIND OF BUSINESS OR INDUSTRY
Vilma Theatre | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
George Horstschneider | | 14. MOTHER'S MAIDEN NAME
Anna Watter | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Catherine Carnes, dght, above | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Cerebral arteriosclerosis
DUE TO
(c) Generalized arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH
2 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
arteriosclerotic cardiac vascular disease | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 2-5 , 19 62 , to 4-10 , 19 62 , that I last saw the deceased alive on 4-9 , 19 62 , and that death occurred at 6:30 A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE
John J. Gould M.D. | | DATE SIGNED | |
| PHYSICIAN'S NAME (Type)
JOHN J GOULD | | 147 E. Calver Baltimore - 24 2nd | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
4/13/62 | 22c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | 22d. LOCATION (City, town, or county) (State)
Baltimore, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles E. Schimunek ADDRESS
3331 Brehms Lane | | 24a. REC'D BY REGISTRAR
DATE APR 12 '62 | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hume |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
04315
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04311

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u> | | c. LENGTH OF STAY IN 1b
<u>2yr2mth25dys</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> <u>29</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>SPRING GROVE STATE HOSPITAL</u> | | | | d. STREET ADDRESS
<u>1023 Elmridge Avenue</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Mattie</u> Middle <u>Henrietta</u> Last <u>Schmidt</u> | | | | 4. DATE OF DEATH
Month <u>April</u> Day <u>10</u> Year <u>1962</u> | | | |
| 5. SEX
<u>female</u> | | 6. COLOR OR RACE
<u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Oct. 15, 1883</u> <u>78</u> yrs. | |
| 9. AGE (in years last birthday)
<u>78</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>unknown (none)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Housewife</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U. S.</u> | | | | 13. FATHER'S NAME
<u>August Clay</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>Louisa Sonn</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)
<u>unknown</u> | | | |
| 16. SOCIAL SECURITY NO.
<u>none</u> | | | | 17. INFORMANT
<u>Records: SPRING GROVE STATE HOSPITAL</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis, severe</u>
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>422.0</u> | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
<u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Jan. 15, 1960</u> , to <u>April 10, 1962</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 10, 1962</u> , and that death occurred at <u>11:30 P.</u> M., from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Stella Wachler</u> M.D. | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>4-11-62</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Stella Wachler, M. D.</u> | | | | 22d. ADDRESS
<u>SPRING GROVE STATE HOSPITAL</u>
<u>Catonsville 28, Maryland</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>4-14-62</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>St. John's Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>Parkville</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Wm. Cook, Inc., 1217 St. Paul Street, Baltimore 2</u> | | | | 25a. REC'D BY REGISTRAR
<u>APR 13 '62</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles E. Hines</u> | |

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U.S. Cook, Inc., 1215 31. Paul Street, Baltimore 7
31. John's Cemetery
Baltimore

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04312

Reg. Dist. No.

FOR STATE HEALTH DEPT.

04312

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8326 Bletzer Road | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk
d. STREET ADDRESS 8326 Bletzer Road
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First ANNA MARIE Middle SCHOEFFIELD Last | | 4. DATE OF DEATH
Month April Day 24 Year 19 62 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 18, 1893 |
| 9. AGE (In years last birthday) 68 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
at home | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Ludwig Grill | | 14. MOTHER'S MAIDEN NAME
Theresa Fuchs | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Joseph Schoeffield, husband, above | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
DUE TO (b) A-S-C-V Disease
DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | |
| 20f. (City or town)
19 | | (County)
(State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
M. B. Davis | | DATE SIGNED
4/25/62 | |
| EXAMINER'S NAME (Type)
M. B. Davis | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
4/27/ 62 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 22d. LOCATION (City, town, or county) (State)
Woodlawn, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles E. Schimunek | | ADDRESS
Funeral Home | |
| 24a. REC'D BY REGISTRAR
DATE APR 26 '62 | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Evans | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04317

04313

| | | | | | | | |
|---|--|-------------------------------------|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Parkville</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Parkville</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>6322 Sherwood Road</u> | | | | d. STREET ADDRESS
<u>6322 Sherwood Road</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>Cornelius Schriver (Schriver) Sr.</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>4-27 19 62</u> | | | |
| 5. SEX
<u>male</u> | | 6. COLOR OR RACE
<u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Jan. 2, 1882</u> | |
| 9. AGE (In years last birthday)
<u>80</u> yrs. | | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Ret. Cement Finisher</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Maryland</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Richard Schriver</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Elizabeth J. Reilly</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) | | | | 16. SOCIAL SECURITY NO.
<u>Bertha Schriver</u> | | | |
| 17. INFORMANT
<u>same</u> | | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u>
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>5/13</u> to <u>4/27</u> , 19 <u>62</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>4/25</u> , 19 <u>62</u> , and that death occurred at <u>6:45</u> M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>W. M. Smith</u> | | | | 22b. DATE SIGNED
<u>4/27/62</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | 22d. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>burial</u> | | 23b. DATE THEREOF
<u>4-30-62</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Gardens of Faith</u> | | 23d. LOCATION (City, town or county) (State)
<u>Baltimore, Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Leonard J. Ruck Inc</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>MAY 4 '62</u> | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | | | |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04318

04314

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville
c. LENGTH OF STAY IN 1b
208 S. Symington Ave Apt B
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 208 S. Symington Ave Apt B | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Md
b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville
d. STREET ADDRESS 208 S. Symington Ave Apt B
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Arthur Walter Schwarz
4. SEX Male
5. RACE White
6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
7. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Oct. 5, 1891
9. AGE (in years if under 1 year, last birthday) 70 yrs.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman - West Chemical Products Co.
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Schwarz
14. MOTHER'S MAIDEN NAME Christinia
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
16. SOCIAL SECURITY NO. 212-03-3315
17. INFORMANT Mrs. Ottilia Schwarz Address 208 S. Symington Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1
DUE TO Coronary thrombosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
DATE SIGNED 4-26-62
Address (Street, city, town, or county) 1010 Leads Ave. (State) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 4-30-62
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery
22d. LOCATION (City, town, or county) Baltimore, Md. | | 24a. REC'D BY REGISTRAR APR 30 '62
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus | |
| 23. FUNERAL DIRECTOR Wm J. Sackewitz Address Balto 17, Md | | | |

100-100000

100-100000

Bellevue

to

Bellevue



Bellevue

Bellevue

200 S. Washington Ave. 3

200 S. Washington Ave. 3

April 26, 1932

April 26, 1932

to

Oct. 7, 1931

Oct. 7, 1931

200 S. Washington Ave. 3

Bellevue

100-100000

1010 Locals Ave.

100-100000

TO HOSPITAL
TO FUNERAL DIRECTOR:
TO HOSPITAL
TO FUNERAL DIRECTOR:
TO HOSPITAL
TO FUNERAL DIRECTOR:

MEDICAL CERTIFICATION

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>
c. LENGTH OF STAY IN lb
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>805 Wellington Road #12</u> | | | | | | | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>
d. STREET ADDRESS <u>805 Wellington Road #12</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Esther</u> | | | | First Middle Last <u>Schwarz</u> | | | | 4. DATE OF DEATH <u>April 15, 1962</u> | | | | Month Day Year | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. SEX <u>Female</u> | | | | 6. COLOR OR RACE <u>White</u> | | | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH <u>March 2, 1901</u> | | | | 9. AGE (In years last birthday) <u>61</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | | | | | | | | | | | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | 11. BIRTHPLACE (County & State, or foreign country) <u>Minnesota</u> | | | | | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | | | | | | | | | |
| 13. FATHER'S NAME <u>Frank Elm</u> | | | | | | | | 14. MOTHER'S MAIDEN NAME <u>Emma Hawkins</u> | | | | | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) | | | | | | | | 16. SOCIAL SECURITY NO. <u>163</u> | | | | | | | | 17. INFORMANT <u>Mrs. Judy Burkley-805 Wellington Road-Balto. 12, Md</u> Address | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
<u>163</u> IMMEDIATE CAUSE (a) <u>Carcinoma of the lung</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 yrs.</u>
DUE TO (c) | | | | | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>6-17</u> <u>1960</u> to <u>4-15</u> <u>1962</u> , that (I) (we) last saw the deceased alive on <u>4-14</u> <u>1962</u> , and that death occurred at <u>4:15 p.m.</u> from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>Charles H. O'Donnell</u> M.D. | | | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>4-16-62</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Charles O'Donnell</u> | | | | | | | | 22d. ADDRESS <u>7501 York Road</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 23b. DATE THEREOF <u>4-17-62</u> | | | | 23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u> | | | | 23d. LOCATION (City, town or county) (State) <u>Pikesville, Maryland</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Tucker & Son</u> | | | | | | | | ADDRESS <u>Baltimore, Md.</u> | | | | | | | | 25a. REC'D BY REGISTRAR <u>APR 17 '62</u> | | | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u> | | | | | | | | | | | | | | | | | | | |

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 7 Film G311 4/16/62 mh

04319

04315

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VR A15 (4)
15M 9/60



1-04-1940

1-04-1940

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04316

04320

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY - ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CATONSVILLE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE 3401-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
House in the Pines | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) John J. Shea Sr. | | 4. DATE OF DEATH April 18, 1962 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/4/1878 |
| 9. AGE (In years last birthday) 84 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JAMES R. SHEA | | 14. MOTHER'S MAIDEN NAME Bridget McAvory | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - | | 16. SOCIAL SECURITY NO. - | |
| 17. INFORMANT Mr. John J. Shea | | Address 919 Lynvue Ave. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA
493 X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - DUE TO (c) - | | | INTERVAL BETWEEN ONSET AND DEATH
3 PM |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | 20d. INJURY OCCURRED
White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from July, 1952 to APRIL 18, 1962 that I last saw the deceased alive on APRIL 17, 1962 and that death occurred at 7:15 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Herbert W. Lapp, M.D.
4804 FREDERICK AVE. BALTIMORE 29, MD. — MI 4-3655 | | ADDRESS (Street, city or town, state) 4804 Frederick Ave. Baltimore, Md. DATE SIGNED 4/18/62 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF 4/21/1962 | |
| 22c. NAME OF CEMETERY OR CREMATORY
New Cathedral | | 22d. LOCATION (City, town, or county) (State)
BALTO. MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
G. Truman Schwab | | 24a. REC'D BY REGISTRAR
DATE APR 23 '62 | |
| ADDRESS
3512 Fred. Ave. | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

30.4.18

01-11-2003

200

24/11/1942

John A. Zuercher

5710 3444

57.114

847-276

May 1944

23067 9 23068

BRIDGE

Mr. John T. Shaw

15.12

7/31/1962 New Cathedral

2. Thomas G. Smith, 2nd

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/58

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | | |
|--|--|---|---------------------------------|--|--|---|--|--|---|--|--|
| 04321 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| Reg. Dist. No. 04317 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY - | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON | | | | | c. LENGTH OF STAY IN 1b 1 WEEK | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) ARMACOST NURSING HOME 812 REGESTER | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First HARRY Middle CLIFTON Last SHRECK | | | | | 4. DATE OF DEATH Month APRIL Day 4 Year 19 62 | | | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH AUG. 5, 1889 | | 9. AGE (In years last birthday) 72 yrs. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist Retired | | 10b. KIND OF BUSINESS OR INDUSTRY 15 Years | | 11. BIRTHPLACE (State or foreign country) Baltimore Maryland | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | | | | |
| 13. FATHER'S NAME George T. Shreck | | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Hofferberth | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War # 1 | | | | | 16. SOCIAL SECURITY NO. 1 6116 A. | | | | | | |
| 17. INFORMANT Mr. Milton Shreck | | | | | 18. ADDRESS 3601 Greenway Apt. 311 Balto. 18, MD. | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
420.0 DUE TO Myocardial insufficiency
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
(c)
INTERVAL BETWEEN ONSET AND DEATH 5 min
15 mos | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | 20f. (City or town) (County) (State) | | | | | | |
| 21. I certify that I attended the deceased from Jan 61 , to April 3, 1962 , that I last saw the deceased alive on Apr 3, 1962 , and that death occurred at 12:10 PM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 2900 E Baltimore St DATE SIGNED Charles L. Maathuis | | | | | | | | | | | |
| ACTUAL SIGNATURE Charles L. Maathuis M.D. 2900 E Baltimore St | | | | | | | | | | | |
| PHYSICIAN'S NAME (Type) Charles L. Maathuis | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 22b. DATE THEREOF 4/7/62 | | | 22c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEMETERY | | | 22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC BALTIMORE MD. | | | | | 24a. REC'D BY REGISTRAR APR 6 '62 | | | | | 24b. REGISTRAR'S SIGNATURE Arthur L. Maathuis | |

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
04318

| | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Dundalk | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Dundalk | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
6914 Homeway | | | | d. STREET ADDRESS
6914 Homeway | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First LEROY Middle E Last SHUPE | | | | 4. DATE OF DEATH
April 7 19 62 | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
11-6-02 | | | |
| 9. AGE (In years last birthday)
59 yrs. | | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Railroader | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Pennsylvania | | | |
| 13. FATHER'S NAME
Edward Shupe | | | | 14. MOTHER'S MAIDEN NAME
Pricilla Walker | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | | | 16. SOCIAL SECURITY NO. | | | | | |
| 17. INFORMANT
Mrs. Ella Shupe Shupe, 6914 Homeway, Dundalk 22 | | | | Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 163X Carcinoma of the lungs DUE TO
Conditions, if any, which gave rise to immediate cause (b) } DUE TO
(a), stating the underlying cause last. (c) } | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Apr 5 1962 to Apr 7 1962 that (I) (we) last saw the deceased alive on Apr 5 1962 and that death occurred at 11:15 AM , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
Stephen P. Mackowiak M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
4-9-62 | | | |
| 22c. PHYSICIAN'S NAME (Type)
S.P. MACKOWIAK | | | | 22d. ADDRESS
6714 Holbrook Ave | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4-11-62 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION (City, town or county) (State)
Balto. Co., Md | | | |
| 24 FUNERAL DIRECTOR'S SIGNATURE
Ullrich Funeral Home, Dundalk, Md. | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
APR 16 62
DATE | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Harris | | | | | |

81340

05230

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04319

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
e. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, MD.
c. LENGTH OF STAY IN 1b June 25, 1959
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Training School | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
e. STATE Maryland
b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville
d. STREET ADDRESS 5114 Baltimore Blvd.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Dennis Middle James Last Slunt | | | | 4. DATE OF DEATH
Month April Day 20 Year 1962 | | | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
March 26, 1958 | | 9. AGE (In years last birthday) 4 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Dependent | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Unknown | | | | 11. BIRTHPLACE (County & State, or foreign country)
Prince Georges - Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
Bessie Cecelia Slunt | | | | Address 4209 Oglethorpe St. | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. NONE | | | | 17. INFORMANT
Institutional Records | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia
(b) complicating congenital cerebral defect.
(c) defect.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
8 hrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital cerebral defect with microcephaly, convulsive disorder, severe
Severe
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (If this hospital) attended the deceased from 6-25-1959 to 4-20-1962 that (I) (we) last saw the deceased alive on 4-20-1962 , and that death occurred at 6:55 A.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Edward J. Matthews M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22b. DATE SIGNED
4-21-62 | | | |
| 22c. PHYSICIAN'S NAME (Type)
Edward J. Matthews, M.D. | | | | 22d. ADDRESS
Rosewood State Tr School
Owings Mills, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4-24-62 | | 23c. NAME OF CEMETERY OR CREMATORY
Southern Methodist | | 23d. LOCATION (City, town or county) (State)
Savage, Maryland | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
W. W. Chambers | | | | ADDRESS
5801 Cleveland Ave
Riversdale Md | | 25a. REC'D BY REGISTRAR
APR 26 '62 | | 25b. REGISTRAR'S SIGNATURE
William S. Thane | | | |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been signed by the attending physician and completely filled out by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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VR A15 (4)
15M 9/60

03040

03040

(M)



Edward Smith

My dear

(C)



Yours truly,
Edw. Smith
11/1/10
11/1/10
11/1/10

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04325
04321

| | | | | | | | |
|--|------------------------------|---|---|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Balto. Co. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Md. b. COUNTY Balto. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
White Marsh | | c. LENGTH OF STAY IN lb
Life | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
White Marsh | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Cowenton Avenue Box 322 | | | | d. STREET ADDRESS
Cowenton Avenue Box 322 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) Fredrick William Snitker | | | | 4. DATE OF DEATH
April 9 1962 | | | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Aug. 6, 1879 | | 9. AGE in years last birthday
82 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Accountant | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Balto Md. | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 13. FATHER'S NAME
John Snitker | | | | 14. MOTHER'S MAIDEN NAME
Annie Unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
212-01-3625 | | 17. INFORMANT
Mrs Nora Snitker Box 322 Cowenton Ave. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
DUE TO Severe Arteriosclerosis Cerebral and Cardiovascular
Conditions, if any, which gave rise to immediate cause (b)
DUE TO 6 yrs.
cause last. (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 2Dc. TIME OF INJURY
Hour a.m. p.m. 19 | | 2Dd. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Spring 1958 to April 1962 , that (I) (we) last saw the deceased alive on April 6 1962 , and that death occurred at 7:50 AM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
William H. Tyson M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
4-9-62 | |
| 22c. PHYSICIAN'S NAME (Type) | | | | 22d. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4-11-1962 | | 23c. NAME OF CEMETERY OR CREMATORY
St Michaels Cemetery | | 23d. LOCATION (City, town or county) (State)
Baltimore Co. Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Lassahn Funeral Home 7401 Belair Road #6 Md. | | | | 25a. REC'D BY REGISTRAR
DATE APR 10 '62 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Thomas | |

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TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04326
CERTIFICATE OF DEATH

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
- | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. LENGTH OF STAY IN lb
13 Days | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Veterans Administration Hospital | | d. STREET ADDRESS
3523 Third Street | |
| 3. NAME OF DECEASED
(Type or print)
JOSEPH C. SOMERVILLE | | 4. DATE OF DEATH
Month April Day 3 Year 1962 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
February 24, 1907 |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk | | 9b. AGE (In years last birthday)
55 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY
Food Market | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
John C. Somerville | | 14. MOTHER'S MAIDEN NAME
Ella Farrell | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
Yes WW II | | 16. SOCIAL SECURITY NO.
215-10-7661 | |
| 17. INFORMANT
CLINICAL RECORDS | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PERITONITIS DUE TO GANGRENE OF SMALL BOWEL DUE TO OBSTRUCTION
DUE TO 570.2
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.
DUE TO 2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
PULMONARY EMPHYSEMA. BRONCHOPNEUMONIA, TERMINAL-Duration 2 Days | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH
10 DAYS | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m.
p.m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from March 21, 1962 , to April 3, 1962 , that (X) (we) last saw the deceased alive on April 3, 1962 , and that death occurred at 2:35 A.M. , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Sebastian Russo | | 22b. DATE SIGNED
4/3/62 | |
| 22c. PHYSICIAN'S NAME (Type)
SEBASTIAN RUSSO, M.D. | | 22d. ADDRESS
VA HOSPITAL, FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4-6-62 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cemetery | | 23d. LOCATION (City, town or county) (State)
Baltimore 28, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
James L. McCully | | 25a. REC'D BY REGISTRAR
DATE APR 6 '62 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur J. Thomas | | | |

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|---------------------------------------|--|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 04327 CERTIFICATE OF DEATH 04323 | | | | | | | | | |
| 1. PLACE OF DEATH
e. COUNTY <u>Baltimore</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 12</u> | | | c. LENGTH OF STAY IN 1b <u>5 mos.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 12</u> | | | d. STREET ADDRESS <u>7120 Sheffield Rd.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holly Hill N. H.</u> | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Sarah Hodges Speake</u> | | | | | 4. DATE OF DEATH <u>April 2 1962</u> | | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>3-8-1870</u> | | 9. AGE (In years last birthday) <u>92</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>Thomas Oden Hodges</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary N. Clagett</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mrs. Emory B. Kaufman</u> Address <u>Above</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
<u>420.0</u> IMMEDIATE CAUSE (a) <u>Pneumonia - hypostatic</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u>
DUE TO (c) <u>Generalized arteriosclerosis</u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 days</u>
<u>years</u>
<u>years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour e.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) <u>(physician)</u> attended the deceased from <u>June 1959</u> , 19 <u> </u> , to <u>April 2</u> , 19 <u>62</u> , that (I) <u>last</u> saw the deceased alive on <u>March 29</u> , 19 <u>62</u> , and that death occurred at <u>11 am</u> from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>S. J. Venable, Jr. M.D.</u> | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22b. DATE SIGNED <u>April 3, 1962</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>S. J. Venable, Jr. M.D.</u> | | | | | 22d. ADDRESS <u>7215 York Road, Baltimore 12, Md</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>4-5-62</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Old Durham Church</u> | | | 23d. LOCATION (City, town or county) (State) <u>Trionsides Md.</u> | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins & Sons Co.</u> | | | | | 25e. REC'D BY REGISTRAR <u>APR 3 '62</u> | | 25b. REGISTRAR'S SIGNATURE <u>Caroline S. Thomas</u> | | |

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04328

04324

| | | | | | | | |
|---|---|---|---|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Md. b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Baltimore 28 | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Baltimore (Catonsville) | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Walker Avenue | | | | d. STREET ADDRESS
Walker Avenue | | | |
| 3. NAME OF DECEASED
(Type or print)
Alice L. Stabler | | | | 4. DATE OF DEATH
Month April Day 15 Year 19 62 | | | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 20, 1884 | | 9. AGE (In years last birthday)
77 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
William Newman | | | | 14. MOTHER'S MAIDEN NAME
Elizabeth J. (Unknown) | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Edmund Stabler 1230 Circle Drive #27 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic interstitial pneumonitis
4-21-62 DUE TO Emphysema
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Chr. valvular heart disease
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).
✓ | | | | | | INTERVAL BETWEEN ONSET AND DEATH
++ years
++ years
++ yrs | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
✓ | | | |
| 20c. TIME OF INJURY
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at..... M., from the causes and on the date stated above.
April 14 19 62 4P 30 9 12 15 62 | | | | | | | |
| 22a. SIGNATURE
Frederic Beitler M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
Frederic Beitler, M. D. | | | | 22d. ADDRESS
1014 Francis Avenue #27 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/18/62 | | 23c. NAME OF CEMETERY OR CREMATORY
Stablersville Cemetery | | 23d. LOCATION (City, town or county) (State)
Stablersville, Maryland | |
| 24 FUNERAL DIRECTOR'S SIGNATURE
Howard H. Hubbard | | | | ADDRESS
4107 Wilkens Avenue #29 | | 25a. REC'D BY REGISTRAR
DATE APR 18 '62 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Harris | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1934

1934



Edward H. Hubbard, 11107 Wilshire Avenue, Los Angeles, California

Walter H. Hubbard, 11107 Wilshire Avenue, Los Angeles, California

Walter H. Hubbard, 11107 Wilshire Avenue, Los Angeles, California

Walter H. Hubbard, 11107 Wilshire Avenue, Los Angeles, California

Walter H. Hubbard, 11107 Wilshire Avenue, Los Angeles, California

Walter H. Hubbard, 11107 Wilshire Avenue, Los Angeles, California

[Faint, mostly illegible handwritten notes and signatures in the center of the page.]

Walter H. Hubbard, 11107 Wilshire Avenue, Los Angeles, California

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TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|---|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 04325 | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Harford ✓ | | | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Owings Mills | | | | | c. LENGTH OF STAY IN 1b
6 months | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Rosewood State Training School | | | | | d. STREET ADDRESS
Swan Harbor Dell Trailer Park | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
Gerald Raymond STARK | | | | | 4. DATE OF DEATH
4 23 19 62 | | | | | | | | | |
| 5. SEX
male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
11/11/59 | | 9. AGE (In years last birthday)
2 yrs. | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
dependent | | 10b. KIND OF BUSINESS OR INDUSTRY
none | | 11. BIRTHPLACE (County & State, or foreign country)
Harford County, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | a. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 13. FATHER'S NAME
Howard Jones | | | | | 14. MOTHER'S MAIDEN NAME
Delores Jean Stark | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
no | | | | | 16. SOCIAL SECURITY NO.
none | | | | | 17. INFORMANT
Mrs. Robert D. Frank, Havre de Grace, Md.
Rosewood Records, Owings Mills, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac failure, secondary to coarctation
754.6 DUE TO (b) Of the aorta and reduplication of
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) mitral valve. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Atonic Deplegia | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY
Month, Day, Year
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (this hospital) attended the deceased from 10/16 to 4/23 , 19 62 , that (we) last saw the deceased alive on 4/23 , 19 62 , and that death occurred at 1:45 a.m. on the causes and on the date stated above. | | | | | | | | | | 22a. SIGNATURE
Harry G. Butler
M.D. | | 22b. DATE SIGNED
24 April 62 | | |
| 22c. PHYSICIAN'S NAME (Type)
Harry G. Butler, M.D. | | | | | 22d. ADDRESS
Rosewood Lane, Owings Mills, Maryland | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Apr. 26, 1962 | | 23c. NAME OF CEMETERY OR CREMATORY
Cokesbury Memorial | | 23d. LOCATION (City, town or county) (State)
Abingdon, Harford, Md., | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
H. K. McElroy
Abingdon, Md. | | | | | 25a. REC'D BY REGISTRAR
APR 27 '62 | | 25b. REGISTRAR'S SIGNATURE
Arthur L. House | | | | | | | |

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VR AIS (4)
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01330

Baltimore

Baltimore

Baltimore

Baltimore

Baltimore

11 State Avenue

11 State Avenue

BESSIE

STEWACH

April 19

63

Female White

64

Housewife

Age 40

Washington, D. C.

USA

Harriet Levy

(Unknown)

11 State Avenue

Samuel Steinhach

201 Levenson & Sons, Inc. 4010 Resurrection Rd. Baltimore, Maryland
Date: Nov 1, 1963
Only female congregation Baltimore, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

Bo

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|------------------|---|--|---|---|--|------------------------------|---|----------------------------|---|---------|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 04331 | | | | | 04327 | | | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | | |
| a. COUNTY | | Baltimore | | | a. STATE | | Md. | | | | |
| | | MARYLAND | | | b. COUNTY | | Baltimore | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | Baltimore | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | | | | | |
| | | Baltimore | | | Baltimore | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | | d. STREET ADDRESS | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 1234 Vogt Avenue | | | | | 1234 Vogt Avenue | | | | | | |
| 3. NAME OF DECEASED
(Type or print) | | First | | Middle | Last | 4. DATE OF DEATH | | Month | Day | Year | |
| Lola | | B. | | Stivers | April | | 11, | 19 | 62 | | |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| female | white | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | June 29, 1913 | | 48 yrs. | | Months | Days | Hours | Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY? | | | | |
| checker | | Aetna Shirt Co. | | Maryland | | | U. S. A. | | | | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | | | |
| Joseph I. Wideman | | | | | Lola E. Tyson | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | |
| no | | | | George A. Stivers, 1234 Vogt Avenue #27 | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Rheumatic fever heart disease | | | | | | | | | | | |
| 401.5 DUE TO (b) Rheumatic fever | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY | | Month, Day, Year | | 20d. INJURY OCCURRED | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | (State) |
| Hour a.m.
p.m. | | 19 | | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from April 10, 1962, to April 11, 1962, that (I) (we) last saw the deceased alive on April 10, 1962, and that death occurred at 10:30 A.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | | | |
| I. Earl Pass, M. D. | | | | | 4001 Wilkens Avenue #29 | | 4-12-62 | | | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town or county) | | (State) | | | |
| Burial | | 4/14/62 | | Woodlawn Cemetery | | Baltimore Co., Maryland | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Howard H. Hubbard, 4107 Wilkens Avenue #29 | | | | | | | DATE APR 13 '62 | | Arthur L. Hanna | | |

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04332

CERTIFICATE OF DEATH

Item 4 Film G310 4/9/62 iwk

04328

| | | | | | | | |
|--|----------------------------------|---|---|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Towson, 4
c. LENGTH OF STAY IN 1b
4
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
8302 Loch Raven Blvd. 4 | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE
Maryland
f. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson, 4 Md.
d. STREET ADDRESS
8302 Loch Raven Blvd 4
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
T. Armour Streett | | 4. DATE OF DEATH
Month
April
Day
2
Year
1962 | | | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 14, 1888 | 9. AGE (In years last birthday)
73 yrs. | IF UNDER 1 YEAR
Months
7
Days
16 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Superintendent | | 10b. KIND OF BUSINESS OR INDUSTRY
Building Con. | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | |
| 13. FATHER'S NAME
Abram T. Streett | | 14. MOTHER'S MAIDEN NAME
Irene Burton | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
(If yes give number or dates of service) | | 17. INFORMANT
Irene D. Streett-8302 Loch Raven Blvd.
Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420-1 Coronary Thrombosis
DUE TO
Conditions, if any, which gave rise to immediate cause (b) arteriosclerotic Heart Disease
(c) Coronary Thrombosis First attack
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
Instant
16 yrs.
16 yrs. | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) | | 20g. (County) | | 20h. (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 8-4 , 19 58 to 4-2 , 19 62 that (I) (we) last saw the deceased alive on 4-2 , 19 62 and that death occurred at 4:45 AM, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Robert H. Siver | | 22b. PHYSICIAN'S NAME (Type)
R. H. Siver | | 22c. ADDRESS
3105 N. Charles St. 18. | | | |
| 22d. DATE
4-2-62 | | 22e. SIGNATURE
Arthur L. Thane | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/4/62 | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge | | | |
| 23d. LOCATION (City, town or county)
Baltimore, Maryland | | 23e. (State)
Maryland | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Wm Cook-Towson, Inc. Towson, Maryland | | 24a. ADDRESS
Towson, Maryland | | 24b. REC'D BY REGISTRAR
APR 4 '62 | | | |
| 24c. DATE
APR 4 '62 | | 24d. REGISTRAR'S SIGNATURE
Arthur L. Thane | | | | | |

in Cook-Townson, Inc. Townson, Maryland
April 1962
David Ridge

Handwritten signature
N. H. Siver

3102 N. Charles St. 18
X
8-4 442
8-4 28 4-4-62

Handwritten notes:
Cassidy Thru-bore first attack 10-1-62
Carter's Thru-bore first attack 10-1-62
Cassidy Thru-bore

Irene D. Street-8302 Loch Haven Blvd.
Irene Burton

Adam T. Street

Building Con. Maryland

Superintendent

Male

14, 1888

Street

L. Arthur

8302 Loch Haven Blvd. #

Townson, #

Townson, #

Albion

Albion

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04828

04333

CERTIFICATE OF DEATH

Reg. Dist. No. 04329

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevenson</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevenson</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>"Lustra"</u> | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>NORMAN</u> Middle <u>STUMP</u> Last <u>STUMP</u> | | | | 4. DATE OF DEATH
Month <u>April</u> Day <u>26</u> Year <u>19 62</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>(W)</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>10-13-1862</u> | |
| 9. AGE (In years lost birthday) <u>99</u> yrs. | | IF UNDER 1 YEAR
Months <u>99</u> Days <u>99</u> Hours <u>99</u> Min. <u>99</u> | | IF UNDER 24 HRS.
Months <u>99</u> Days <u>99</u> Hours <u>99</u> Min. <u>99</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | |
| 13. FATHER'S NAME <u>Captian Rueben Stump</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Margaret Wilson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>Span-American</u> | | | | 16. SOCIAL SECURITY NO. <u>---</u> | | 17. INFORMANT <u>J. W. Middendorf</u> Address <u>Ruxton, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Gangrene left foot -</u>
<u>422.1</u> DUE TO <u>greenish artus - sclerotic</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO <u>artus - sclerotic Cardiovascular disease</u>
(c) <u>10 years</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 months</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month <u>Dec</u> Day <u>16</u> Year <u>19 46</u>
Hour <u>a. m.</u> p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) <u>Swings Mills</u> | | | | 20g. (County) <u>Calvert</u> | | 20h. (State) <u>Md.</u> | |
| 21. I certify that I attended the deceased from <u>Dec 16</u> , 19 <u>46</u> to <u>April 26</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>April 25</u> , 19 <u>62</u> , and that death occurred at <u>2 P. M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Palmer F. Williams</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Swings Mills</u> | | | |
| DATE SIGNED <u>Apr 26 62</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>Palmer F. Williams</u> | | | | M.D. <u>Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>4-28-62</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas'</u> | | 22d. LOCATION (City, town, or county) <u>Garrison Forest</u> (State) <u>Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H. W. Jenkins & Sons Co.</u> ADDRESS <u>4905 York Rd., Balto., Md.</u> | | | | 24a. RECEIVED BY REGISTRAR <u>APR 30 62</u> DATE | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04334

04330

| | | | | | | | |
|--|---|---|---|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural- Baltimore 7 | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X Rural- Baltimore 7 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
6924 Dogwood Road | | | | d. STREET ADDRESS
6924 Dogwood Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Mr. Harry | | E. Subock | | 4. DATE OF DEATH
April 19 1962 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
August 25, 1899 | | 9. AGE (In years last birthday)
62 yrs. | IF UNDER 1 YEAR
Months 7 Days 19 | IF UNDER 24 HRS.
Hours 19 Min. 62 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Superintendent | | 10b. KIND OF BUSINESS OR INDUSTRY
Balto. Co. Bureau of Utilities | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John H. Subock | | | | 14. MOTHER'S MAIDEN NAME
Nettie Reely | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
No | | 16. SOCIAL SECURITY NO.
218-09-4456 | | 17. INFORMANT
Mrs. Bessie R. Subock, Baltimore 7, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC CARDIO VASCULAR Dis.
DUE TO 241X
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.
(b) BRONCHIAL ASTHMA
DUE TO 10 yrs.
(c) 3 yrs. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from OCT 1946 to APRIL 1962 , that (I) (we) last saw the deceased alive on 4/19/62 , and that death occurred at 6:20 PM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Norman R. Kleiman | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
4/20/62 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Norman R. Kleiman | | | | 22d. ADDRESS
3803 Edmondson Ave., Baltimore 29, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Apr. 23, 1962 | | 23c. NAME OF CEMETERY OR CREMATORY
Lake View Memorial Park | | 23d. LOCATION (City, town or county) (State)
Baltimore County, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Erving Byers | | | | 25a. REC'D BY REGISTRAR
DATE APR 23 '62 | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Thane | |

03330

CERTIFICATE OF DEATH

1933

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1933

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04335

04331

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
TOWSON | | c. LENGTH OF STAY IN 1b
2 MON. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
TOWSON CONVALESCENT HOME | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
GERTRUDE G. SUGRO | | 4. DATE OF DEATH Month Day Year
APRIL 4 1962 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
APRIL 22, 1981 |
| 9. AGE (In years last birthday)
80 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | 11. BIRTHPLACE (State or foreign country)
NORTH CAROLINA |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
HARRY GREENLEAF | |
| 14. MOTHER'S MAIDEN NAME
GERTRUDE POOLE | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NONE | |
| 16. SOCIAL SECURITY NO.
— | | 17. INFORMANT
FAMILY RECORDS | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
DUE TO
Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost.
(b) HYPERTENSIVE-ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO
(c) — | | INTERVAL BETWEEN ONSET AND DEATH
3 MONTHS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
SEVERAL CEREBRAL HEMORRHAGES SINCE OCT 1960 | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 3/10 19 62 to 4/4 19 62 that (I) (we) last saw the deceased alive on 4/2 19 62 , and that death occurred at 6 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
T. C. Siwinski | | 22b. DATE SIGNED
4/6/62 | |
| 22c. PHYSICIAN'S NAME (Type)
T. C. SIWINSKI | | 22d. ADDRESS
206 W. PENNA. AVE TOWSON 4 MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
APRIL 7, 1962 | |
| 23c. NAME OF CEMETERY OR CREMATORY
DRUID RIDGE CEMETERY | | 23d. LOCATION (City, town, or county) (State)
PIKEVILLE, MD. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
John Burns' Sons, Towson, Md. | | 25a. REC'D BY REGISTRAR
DATE APR 9 '62 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Parnes | | | |

04331

CERTIFICATE OF DEATH

04331



NAME (PRINT)

OWN HOME

PROPERTY

DECEASED

DECEASED

DATE OF DEATH

AGE

SEX

DECEASED

DECEASED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | | | |
|--|-------------------------------|--|--|--|---|
| 04336 | | Item 8 Film 0311 4/18/62 mh | | 04332 | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville
c. LENGTH OF STAY IN 1b 40 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Slade Ave & Reisterstown Rd. | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville
d. STREET ADDRESS Slade & Reisterstown Rd.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First RAYMOND Middle TAMBURO Last TAMBURO | | 4. DATE OF DEATH
Month April Day 12 Year 1962 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1864
Sept. 11-1867 | 9. AGE (In years last birthday) 97 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Confectionary | | 11. BIRTHPLACE (State or foreign country) Italy | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME Stephen Tamburo | | 14. MOTHER'S MAIDEN NAME Marzula | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. no | | 17. INFORMANT John A. Tamburo Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.0 TERMINAL PNEUMONIA
DUE TO
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) CONGESTIVE HEART FAILURE
DUE TO
(c) ARTERIOSCLEROTIC HEART DISEASE | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 4-9-62 to 4-12-62 that (I) (we) last saw the deceased alive on 4-12-1962 and that death occurred at 11:45P from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE Samuel P. Scalia | | M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 4-16-1962 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Reedmer | |
| 23d. LOCATION (City, town, or county) (State) Belair Rd. Baltimore, Md. | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell | | ADDRESS Pikesville, Md. | | 25a. REC'D BY REGISTRAR APR 16 '62 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Arthur S. Hume | |

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DEPARTMENT OF JUSTICE

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04337

04333

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore | | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. LENGTH OF STAY IN lb
27 Days | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland | | b. COUNTY
- | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Veterans Administration Hospital | | | | d. STREET ADDRESS
1929 McElderry Street | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
JOHN | | First
JOHN | | Middle
V. | | Last
TAUBER | | 4. DATE OF DEATH
Month
April | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
February 7, 1894 | | 9. AGE (In years last birthday)
68 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machine Operator | | 10b. KIND OF BUSINESS OR INDUSTRY
Furniture Factory | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
X U. S. A. | | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. | |
| 13. FATHER'S NAME
John Tauber | | | | 14. MOTHER'S MAIDEN NAME
Mary Biebl | | | | Address
Clinical Records, VA HOSPITAL, FORT HOWARD, MARYLAND | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
Yes WW I | | | | 16. SOCIAL SECURITY NO.
215-03-7496 | | 17. INFORMANT
Clinical Records, VA HOSPITAL, FORT HOWARD, MARYLAND | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BILATERAL PNEUMONIA
Conditions, if any, which gave rise to immediate cause (b) PYELONEPHRITIS
(a), stating the underlying cause last. (c) METASTATIC CARCINOMA, ADRENALS, LYMPH NODES
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 DAYS
Unknown
Site Undet. Unknown | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m.
p.m.
19 | | 20d. INJURY OCCURRED
While et work <input type="checkbox"/> Not While et work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
(County)
(State) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 7, 1962 , to April 3, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 3, 1962 , and that death occurred at 3:45 A.M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
Sebastian Russo | | | | 22b. DATE SIGNED
4/3/62 | | 22c. PHYSICIAN'S
SEBASTIAN RUSSO, M.D. | | | |
| 22d. ADDRESS
VAH, FORT HOWARD, MARYLAND | | | | 22e. ADDRESS
VAH, FORT HOWARD, MARYLAND | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/7/62 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Redeemer Cem | | 23d. LOCATION (City, town or county)
(State)
Belair Road, Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
DIPPEL BROS | | | | ADDRESS
1800 E. LOMBARD ST | | 25a. REC'D BY REGISTRAR
DATE
APR 5 '62 | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Hume | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01337

(1)

John Howard

John Howard

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 shall be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|-----------------------------------|--|--|---|------------------------------|-------------|---------------------------------|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 04338 | | | | | 04334 | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | |
| a. COUNTY | | BALTO. | | | a. STATE | | MD. | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | CATONSVILLE | | | b. COUNTY | | BALTO. | | |
| c. LENGTH OF STAY IN 1b | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | CATONSVILLE | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | | d. STREET ADDRESS | | | | |
| 935 Coleridge Rd. | | | | | 935 Coleridge Rd. | | | | |
| 3. NAME OF DECEASED (Type or print) | | | | | 4. DATE OF DEATH | | | | |
| First Middle Last Gertrude Taylor | | | | | Month Day Year April 8, 1962 | | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | |
| Female | | W. | | | | SEP. 24, 1877 | | 84 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| H. W. | | Own Home | | BALTO. MD. | | U. S. A. | | | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | |
| Oliver Thompson | | | | | Annie | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | | 16. SOCIAL SECURITY NO. | | | | |
| | | | | | Mrs Elmer Scholz, 935 Coleridge Rd | | | | |
| 17. INFORMANT | | | | | Address | | | | |
| | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIO - | | | | | | | | | |
| DUE TO (b) VASCULAR DISEASE | | | | | | | | | |
| DUE TO (c) | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| OSTEOARTHRITIS, SEVERE, & DEFORMITY | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 | | | | | | | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | | | |
| 20f. (City or town) (County) (State) | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 4/8, 1962, to 4/8, 1962 that (I) (we) last saw the deceased alive on 4/8, 1962, and that death occurred at 11 A.M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE | | | | | | | | | |
| 22b. DATE SIGNED | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) Thos E Runch | | | | | | | | | |
| 22d. ADDRESS 5550 BALTO NATL PKWY - 28 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | |
| 23b. DATE THEREOF | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | |
| 23d. LOCATION (City, town or county) (State) | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE | | | | | | | | | |
| 25a. REC'D BY REGISTRAR | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|---|--|---|--|---|---|---|---|---|---|---|---------|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | |
| 04339 CERTIFICATE OF DEATH 04335 | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <i>Baltimore</i> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <i>Md.</i> b. COUNTY <i>-</i> | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Rural-Cockeysville</i> | | | c. LENGTH OF STAY IN 1b
<i>6 yrs.</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Ba Ho.</i> <i>3V04</i> | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<i>Md. Masonia Home</i> | | | | | d. STREET ADDRESS
<i>1123 Eutaw St.</i> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED
(Type or print) <i>Anna Louise Teackle</i> | | | | | 4. DATE OF DEATH
Month <i>April</i> Day <i>17</i> Year <i>1962</i> | | | | | | | | | |
| 5. SEX
<i>Female</i> | | 6. COLOR OR RACE
<i>White</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>Aug. 6, 1874</i> | | 9. AGE (In years last birthday)
<i>87</i> yrs. | | | | | | |
| | | | | | | | | IF UNDER 1 YEAR
Months Days Hours Min. | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
<i>Baltimore City, Md.</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | | | | |
| 13. FATHER'S NAME
<i>Otto Duker</i> | | | | | 14. MOTHER'S MAIDEN NAME
<i>Anna C. Radica</i> | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT
Address <i>Masonia Home Records - Cockeysville</i> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Arteriosclerotic atherosclerotic disease</i> <i>Cyanosis</i>
4-22-62
DUE TO
Conditions, if any, which gave rise to immediate cause (b)
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 20c. TIME OF INJURY
Hour a.m. p.m. <i>19</i> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | | | |
| 21. I certify that (I) (the hospital) attended the deceased from <i>April 14</i> to <i>April 17</i> , 19 <i>62</i> , that (I) (we) last saw the deceased alive on <i>April 14</i> , 19 <i>62</i> , and that death occurred at <i>2:45 PM</i> , from the causes and on the date stated above. | | | | | | | | | | | | | | |
| 22a. SIGNATURE
<i>Elizabeth B. Sherrill</i> M.D. | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<i>4/17/62</i> | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
<i>Elizabeth B. Sherrill M.D.</i> | | | | | 22d. ADDRESS
<i>Cockeysville Md.</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | | 23b. DATE THEREOF
<i>4-19-62</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Loudon Park Cemetery</i> | | | 23d. LOCATION (City, town or county)
<i>Baltimore</i> | | | (State) | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>Wm. Cook, Inc., 1217 St. Paul Street, Baltimore</i> | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE <i>APR 19 '62</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Caroline S. Thomas</i> | | | | | |

LONDON PARK COUNTRY

Flowers & Shrubs for the

St. Paul & Northern

April 14

at 10:00

White

At 10:00 the same time

Flowers & Shrubs for the

Ann C. Radice

Flowers & Shrubs for the

Aug. 1, 1877

Tenants

April 1

1133-10th St.

Del. Co.

Wm.

Otto Duker

Mar. 1, 1877

Female white

Course

Ann

Mr. Martin's time

Flowers & Shrubs for the

Del. Co.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04340

04336

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. LENGTH OF STAY IN 1b
7 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
306 W. Pennsylvania Avenue | | | | d. STREET ADDRESS
306 W. Pennsylvania Avenue | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First JOHN Middle ANDREW Last THORWORTH | | | | 4. DATE OF DEATH
Month April Day 1 Year 1962 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
October 6, 1884 | |
| 9. AGE (In years lost birthday)
77 yrs. | | 10. IF UNDER 1 YEAR
Months 77 Days 77 Hours 77 Min. | | 11. BIRTHPLACE (State or foreign country)
New Jersey | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Contractor- Retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Construction | | 11. BIRTHPLACE (State or foreign country)
New Jersey | |
| 13. FATHER'S NAME
David Thoworth | | | | 14. MOTHER'S MAIDEN NAME
Fronie ? Thoworth | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Family Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY ARTERY OCCLUSION
420-1 DUE TO GENERALIZED ARTERIO SCLEROSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS
INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. 19
p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 2/15 to 4/1/62 , that (I) (we) last saw the deceased alive on 3/30 1962 , and that death occurred at 7:30 A.M., from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
T.C. Siwinski | | | | 22b. DATE SIGNED
4/1/62 | | | |
| 22c. PHYSICIAN'S NAME (Type)
T.C. SIWINSKI | | | | 22d. ADDRESS
206 W. PENNA. AV. TOWSON 4 MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal/Burial | | 23b. DATE THEREOF
April 2, 1962 | | 23c. NAME OF CEMETERY OR CREMATORY
Crest Haven Cemetery | | 23d. LOCATION (City, town, or county) (State)
Clifton, N.J. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
John Burns Sons | | | | ADDRESS
Towson, Maryland | | 25a. REC'D BY REGISTRAR
DATE APR 5 '62 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
S. H. HARRIS | |

1938

CERTIFICATE OF DEATH

1938



Blank certificate form with faint lines and text, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through from the reverse side.

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bP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M
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04341

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04337

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Cockeysville</u>
c. LENGTH OF STAY IN 1b <u>10 years.</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Maryland Masonic Home</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u>
b. COUNTY <u>-</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>
d. STREET ADDRESS <u>4300 Roland Ave</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>Mary</u> <u>E</u> <u>Tingle</u> | | 4. DATE OF DEATH
Month <u>April</u> Day <u>7</u> Year <u>1962</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 21, 1878</u> |
| 9. AGE (In years last birthday) <u>83</u> yrs. | | IF UNDER 1 YEAR
Months <u>83</u> Days <u>83</u> | IF UNDER 24 HRS.
Hours <u>83</u> Min. <u>83</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>USA.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA.</u> | |
| 13. FATHER'S NAME <u>Samuel Moore</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary B. Sommer</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>-</u> | |
| 17. INFORMANT <u>Masonic Home Records - Cockeysville, Md.</u> | | Address <u>Masonic Home Records - Cockeysville, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary artery disease</u>
DUE TO (b) <u>Arteriosclerosis</u>
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>420.1</u>
DUE TO (c) <u>Arteriosclerosis</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour <u>19</u> o.m. <u>19</u> p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1961</u> to <u>Apr 1 1962</u> , that (I) (we) last saw the deceased alive on <u>April 6 1962</u> , and that death occurred at <u>1:30 P</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Elizabeth B. Sherrill</u> M.D. | | 22b. DATE SIGNED <u>Apr 1 1962</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Elizabeth B. Sherrill M.D.</u> | | 22d. ADDRESS <u>Cockeysville, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>4-10-62</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u> | 23d. LOCATION (City, town or county) (State) <u>Baltimore</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street, Baltimore 2</u> | | 25a. REC'D BY REGISTRAR <u>APR 10 '62</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur S. [Signature]</u> | | | |

N

W. Cook, Inc., 1219 82nd Street, Baltimore 2

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04342 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04338

| | | | | | | | |
|--|---|--|--|--|--------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY BALTO. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MD. b. COUNTY BALTO. | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
ESSEX | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
ESSEX | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
407 N. RIVERSIDE RD. | | | | d. STREET ADDRESS
407 N. RIVERSIDE RD. | | | |
| 3. NAME OF DECEASED
(Type or print) CORA SUSANNE TROYER | | | | 4. DATE OF DEATH
Month 4 Day 22 Year 1962 | | | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> SEPARATED | 8. DATE OF BIRTH
MAY 24 - 1874 | 9. AGE (In years last birthday)
87 yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
AT HOME | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
PA. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
JOSEPH FRIDINGER | | | | 14. MOTHER'S MAIDEN NAME
MARY | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
MRS. NELLIE UNFRIED. | | Address
ABOVE | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 443X DUE TO Hypertensive Cardiovascular dis.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
9 yrs | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Jack E. Collins | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED
4-22-62 | |
| EXAMINER'S NAME (Type)
Jack E. Collins | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | Address (Street, city, town, or county) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
4-25-62 | 22c. NAME OF CEMETERY OR CREMATORY
GREENMOUNT U. B | | 22d. LOCATION (City, town, or county) (State)
GREENMOUNT, CARROLL CO. MD. | | | |
| 23. FUNERAL DIRECTOR
John G. Connolly | | | | ADDRESS
418 Eastern Blvd. | | 24a. REC'D BY REGISTRAR
APR 24 '62 | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus |

MEDICAL CERTIFICATION

01338

22819



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Balto. Co MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Balto. Co | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Bradshaw Md | | c. LENGTH OF STAY IN life
Life | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Bradshaw | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Bradshaw Md | | | | d. STREET ADDRESS
Bradshaw Md | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
John H Ulrich Jr. | | | | 4. DATE OF DEATH
4 15 1962 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
10-5-1913 | |
| 9. AGE (In years last birthday)
48 yrs. | | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Expiditer | | 10b. KIND OF BUSINESS OR INDUSTRY
Martin Co. | | 11. BIRTHPLACE (State or foreign country)
Balto. Md | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 13. FATHER'S NAME
John H Ulrich | | | | 14. MOTHER'S MAIDEN NAME
Louisa Breback | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
217-14-2939 | | 17. INFORMANT
Mrs Edna E Ulrich | | Address
Bradshaw Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Stungulation - cervical dislocation
974X DUE TO
Conditions, if any, which gave rise to immediate cause (b) due to hanging.
(a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
DATE SIGNED 4-16-62
ACTUAL SIGNATURE John C. Hyle M.D.
EXAMINER'S NAME (Type) JOHN C. Hyle
Address (Street, city, town, or county) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
4-9-1962 | | 22c. NAME OF CEMETERY OR CREMATORY
St Michael's Luth. Cem. | | 22d. LOCATION (City, town, or country) (State)
Baltimore Co. Md. | |
| 23. FUNERAL DIRECTOR
Lassahn Funeral Home
ADDRESS 7401 Belair Road | | | | 24a. REC'D BY REGISTRAR APR 17 1962
24b. REGISTRAR'S SIGNATURE John J. Hyle
DATE | | | |

IN STATE
WASH DC

1943

04339

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Sex: _____

3. Age: _____

4. Date of Birth: _____

5. Place of Birth: _____

6. Usual Residence: _____

7. Date of Death: _____

8. Time of Death: _____

9. Place of Death: _____

10. Cause of Death: _____

11. Manner of Death: _____

12. Signature of Medical Examiner: _____

13. Signature of Coroner: _____

14. Signature of Registrar: _____

15. Signature of Undertaker: _____

16. Signature of Physician: _____

17. Signature of Nurse: _____

18. Signature of Pathologist: _____

19. Signature of Anatomist: _____

20. Signature of Embalmer: _____

21. Signature of Burial Director: _____

22. Signature of Cemetery: _____

23. Signature of Funeral Home: _____

24. Signature of Mortician: _____

25. Signature of Undertaker: _____

26. Signature of Burial Director: _____

27. Signature of Cemetery: _____

28. Signature of Funeral Home: _____

29. Signature of Mortician: _____

30. Signature of Undertaker: _____

31. Signature of Burial Director: _____

32. Signature of Cemetery: _____

33. Signature of Funeral Home: _____

34. Signature of Mortician: _____

35. Signature of Undertaker: _____

36. Signature of Burial Director: _____

37. Signature of Cemetery: _____

38. Signature of Funeral Home: _____

39. Signature of Mortician: _____

40. Signature of Undertaker: _____

41. Signature of Burial Director: _____

42. Signature of Cemetery: _____

43. Signature of Funeral Home: _____

44. Signature of Mortician: _____

45. Signature of Undertaker: _____

46. Signature of Burial Director: _____

47. Signature of Cemetery: _____

48. Signature of Funeral Home: _____

49. Signature of Mortician: _____

50. Signature of Undertaker: _____

51. Signature of Burial Director: _____

52. Signature of Cemetery: _____

53. Signature of Funeral Home: _____

54. Signature of Mortician: _____

55. Signature of Undertaker: _____

56. Signature of Burial Director: _____

57. Signature of Cemetery: _____

58. Signature of Funeral Home: _____

59. Signature of Mortician: _____

60. Signature of Undertaker: _____

61. Signature of Burial Director: _____

62. Signature of Cemetery: _____

63. Signature of Funeral Home: _____

64. Signature of Mortician: _____

65. Signature of Undertaker: _____

66. Signature of Burial Director: _____

67. Signature of Cemetery: _____

68. Signature of Funeral Home: _____

69. Signature of Mortician: _____

70. Signature of Undertaker: _____

71. Signature of Burial Director: _____

72. Signature of Cemetery: _____

73. Signature of Funeral Home: _____

74. Signature of Mortician: _____

75. Signature of Undertaker: _____

76. Signature of Burial Director: _____

77. Signature of Cemetery: _____

78. Signature of Funeral Home: _____

79. Signature of Mortician: _____

80. Signature of Undertaker: _____

81. Signature of Burial Director: _____

82. Signature of Cemetery: _____

83. Signature of Funeral Home: _____

84. Signature of Mortician: _____

85. Signature of Undertaker: _____

86. Signature of Burial Director: _____

87. Signature of Cemetery: _____

88. Signature of Funeral Home: _____

89. Signature of Mortician: _____

90. Signature of Undertaker: _____

91. Signature of Burial Director: _____

92. Signature of Cemetery: _____

93. Signature of Funeral Home: _____

94. Signature of Mortician: _____

95. Signature of Undertaker: _____

96. Signature of Burial Director: _____

97. Signature of Cemetery: _____

98. Signature of Funeral Home: _____

99. Signature of Mortician: _____

100. Signature of Undertaker: _____

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

I

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|-----------------------------------|--|--|--|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 04340 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ruxton</u> | | | | c. LENGTH OF STAY IN 1b <u>15 yrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ruxton</u> | | | | d. STREET ADDRESS <u>7809 Chelsea St.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7809 Chelsea St.</u> | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Peter</u> Middle <u>Granger</u> Last <u>Vander Pool</u> | | | | | | 4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1962</u> | | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>7-4-1888</u> | | 9. AGE (In years last birthday) <u>73</u> yrs. | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banking</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (County & State, or foreign country) <u>New York</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Augustas Vander Pool</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Eliza Granger</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | | | 16. SOCIAL SECURITY NO. <u>--</u> | | 17. INFORMANT <u>Mrs. W. Wilson White</u> | | Address <u>Above</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>
<u>443X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio Vascular Disease</u>
DUE TO (c) <u>Carcinomatosis extensive</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 hr.</u>
<u>6 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
<u>Carcinoma Prostrate</u> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour e.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept.</u> , 19 <u>47</u> , to <u>4-23</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>4-22</u> , 19 <u>62</u> , and that death occurred at <u>5:10 AM</u> from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>B.H. Rutledge</u> M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>4-23-62</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>B.H. Rutledge, M. D.</u> | | | | | | 22d. ADDRESS <u>18 E. Eager St., Baltimore 2, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | | 23b. DATE THEREOF <u>4-25 -62</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u> | | | 23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u> | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins & Sons Co. 4905 York Rd. balto. 12, Md.</u> | | | | | | 25a. REC'D BY REGISTRAR <u>APR 26 '62</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u> | | | |

04340

04340



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | |
|---|-------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Relay</u> | | c. LENGTH OF STAY IN 1b <u>61 yrs.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1808 Sutton Ave.</u> | | d. STREET ADDRESS <u>1808 Sutton Ave.</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Mary B Vernetson</u> | | 4. DATE OF DEATH <u>April 22 1962</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 16, 1877</u> |
| 9. AGE (in years last birthday) <u>84</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>One Home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Murphy</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | |
| 17. INFORMANT <u>Margaret L. McMahon</u> | | Address <u>1808 Sutton Ave.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary occlusion 2 hrs</u>
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Chr Cardio Vascular disease, 2 yrs</u>
<u>Senility & Hypertension, 10 yrs</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1960</u> to <u>Apr 22 1962</u> that (I) (we) last saw the deceased alive on <u>Apr 20 1962</u> , and that death occurred at <u>11:35 A.M.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>B R Brumbaugh</u> M.D. | | 22b. DATE SIGNED <u>4/23/62</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Brumbaugh M D</u> | | 22d. ADDRESS <u>5609 Main St, Elkridge 27, Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>4/26/62</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery Baltimore, Maryland</u> | | 23d. LOCATION (City, town or county) (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrase, Inc. 1328 Sulphur Spring Rd.</u> | | 25a. REC'D BY REGISTRAR <u>APR 26 '62</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | | |

1931

CERTIFICATE OF DEATH

1931

1931

1931



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04346 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04342

| | | | |
|--|--|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore County MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore Co. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS | |
| Balto. Beltway at Rt. 40 | | 1135 Riverside Avenue | |
| 3. NAME OF DECEASED (Type or print)
First JOHN Middle G. Last VINSON | | 4. DATE OF DEATH
Month April Day 30 Year 19 62 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10-18-44 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Tire | | 9. AGE (In years last birthday) 17 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min. | |
| 10b. KIND OF BUSINESS OR INDUSTRY
School Bus | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Edwin N. Sr. | |
| 14. MOTHER'S MAIDEN NAME
Catherine Fink | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Family Address Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cranio-cerebral injury
819X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH _____ | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
Passenger in auto which ran through barricade at end of beltway | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. Apr. 30, 1962 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Balto. Beltway at Rt. 40, Balto. County, Maryland | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Howard G. Shaub | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
HOWARD G. SHAUB, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED
May 1, 1962 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
B | | 22b. DATE THEREOF
5-4-62 | |
| 22c. NAME OF CEMETERY OR CREMATORY
New Cath Con. | | 22d. LOCATION (City, town, or country) (State)
Balto. Md. | |
| 23. FUNERAL DIRECTOR
Mc Cully Funeral Home | | 24a. REC'D BY REGISTRAR
DATE MAY 2 '62 | |
| ADDRESS
130 E Fort Ave | | 24b. REGISTRAR'S SIGNATURE
William E. Hines | |



Handwritten signature: J. M. Smith

1
TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

I

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | | | |
|--|--|---|---|---|---|---|--|---|----------------------|---|---------------------|---|--|--|---|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | | | | | | |
| 04347 | | | | | | | | | | | | | | | | | | | |
| 04343 | | | | | | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
e. STATE Mary land b. COUNTY - | | | | | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | | c. LENGTH OF STAY IN 1b
4mth8dys | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | d. STREET ADDRESS
772 Canal Street | | | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
First Florence Middle - Last Wagner | | | | | 4. DATE OF DEATH
Month April Day 22 Year 19 62 | | | | | | | | | | | | | | |
| 5. SEX
female | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
April 27, 1893 | | 9. AGE (In years last birthday)
68 yrs. | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
- | | 11. BIRTHPLACE (County & State, or foreign country)
Penna. | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | | | | | | | | | | | | |
| 13. FATHER'S NAME
unknown | | | | | 14. MOTHER'S MAIDEN NAME
unknown | | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
unknown | | | | | 16. SOCIAL SECURITY NO.
unknown | | | | | 17. INFORMANT
Address
Records: SPRING GROVE STATE HOSPITAL | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) arteriosclerotic heart disease
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.
(b) generalized arteriosclerosis
DUE TO
(c) - | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
long standing
11 11 | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
chronic brain syndrome with psychosis due to arteriosclerosis | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
- | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | | 20d. INJURY OCCURRED
While et work <input type="checkbox"/> Not While et work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
- | | 20f. (City or town)
- | | (County)
- | | (State)
- | | | | | | | | |
| 21. I certify that NO (this hospital) attended the deceased from Dec. 9, 1961 , to April 22, 1962 , that NO (we) last saw the deceased alive on April 22, 1962 , and that death occurred at 6:00 M., from the causes and on the date stated above. | | | | | | | | | | 22a. SIGNATURE
Stella Wachsler M.D. | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 5-1-62 | | | | |
| 22c. PHYSICIAN'S NAME (Type)
Stella Wachsler, M. D. | | | | | 22d. ADDRESS
SPRING GROVE STATE HOSPITAL
CATONSVILLE 28, Maryland | | | | | 22b. DATE SIGNED
- | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
buried | | | 23b. DATE THEREOF
May 7, 1962 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Peter's Cem. | | | 23d. LOCATION (City, town or county)
Baltimore, Md. | | | (State)
- | | | | | | | | |
| 24 FUNERAL DIRECTOR'S SIGNATURE
McNabb ---Catonsville, Md. | | | | | ADDRESS
- | | | | | 25a. REC'D BY REGISTRAR
DATE MAY 3 '62 | | 25b. REGISTRAR'S SIGNATURE
Conway L. Haines | | | | | | | |

VR A15 (4)
15M 9/60

1310

1310

1310

(M)

(I)

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
15M 7/61

1
04348
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04344
CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard
c. LENGTH OF STAY IN 1b
6 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Veterans Administration Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X Baltimore 34
d. STREET ADDRESS
3332 Willoughby Road
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
MARY A. WALLIS | | | | 4. DATE OF DEATH
Month Day Year
April 2 2 19 62 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
January 28, 1883 79 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Nurse | | 10b. KIND OF BUSINESS OR INDUSTRY
Nursing | | 11. BIRTHPLACE (County & State, or foreign country)
Worton, Maryland (Worton) | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Samuel W. Wallis | | | | 14. MOTHER'S MAIDEN NAME
Mary Lynch | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WW I | | 16. SOCIAL SECURITY NO.
213-32-9790 | | 17. INFORMANT
Address
Clinical Records VA Hospital, Fort Howard, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
DUE TO
422-1
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.
(b) MYOCARDIAL HEART FAILURE
DUE TO
(c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | INTERVAL BETWEEN ONSET AND DEATH
DAYS
DAYS
YEARS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
CEREBRAL ARTERIOSCLEROSIS | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
March 27, 1962, to April 2, 1962 | | 20g. (County)
1:05 | | 20h. (State)
that X (we) last | |
| 21. I certify that X (this hospital) attended the deceased from March 27, 1962 , to April 2, 1962 , that X (we) last saw the deceased alive on April 2, 1962 , and that death occurred at A.M. from the causes and on the date stated above. | | | | 22a. SIGNATURE
John D. Talbert, M.D. | | 22b. DATE SIGNED
4/2/62 | |
| 22c. PHYSICIAN'S NAME (Type)
JOHN D. TALBERT, Acting Chief, Service | | | | 22d. ADDRESS
VA Hospital, Fort Howard, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/4/62 | | 23c. NAME OF CEMETERY OR CREMATORY
I U Cemetery | | 23d. LOCATION (City, town or county) (State)
Kent County, Maryland | |
| 24. BURIAL DIRECTOR'S SIGNATURE
Willis Wells, Chestertown, Maryland | | | | 25a. REC'D BY REGISTRAR
Willis Wells | | 25b. REGISTRAR'S SIGNATURE
Charles S. Hanna | |

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[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04349

Item 14 Film G312 5/7/62 ind

04345

| | | | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore County | | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Mt. Wilson | | c. LENGTH OF STAY IN 1b
Mt. Wilson State Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Md | | b. COUNTY
Frederick | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Knoxville | | d. STREET ADDRESS
10X-2 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) | | First
Russell | | Middle
Charles | | Last
Watts | | 4. DATE OF DEATH
Month
4 | | Day
29 | | Year
1962 | | | | | |
| 5. SEX
M | | 6. COLOR OR RACE
W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
12/16/103 | | 9. AGE (In years last birthday)
58 yrs. | | IF UNDER 1 YEAR
Months
5 Days
10 | | IF UNDER 24 HRS.
Hours
10 Min.
2 | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Track Hand | | 10b. KIND OF BUSINESS OR INDUSTRY
B & O, P.R. | | 11. BIRTHPLACE (County & State, or foreign country)
West Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Thomas Watts | | 14. MOTHER'S MAIDEN NAME
ELLA WAUGH | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
220-09-7209 | | 17. INFORMANT
Address
Medical records, Mt. Wilson State Hospital | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
002.1
DUE TO
Pulmonary Tuberculosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
Pulmonary Emphysema | | INTERVAL BETWEEN ONSET AND DEATH
16 mo.
6 mo. | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
3/13 | | (County)
1962 | | (State)
to 4/29, 1962 | | 21. I certify that (I) (this hospital) attended the deceased from 3/13 1962 to 4/29 , 1962 , that (I) (we) last saw the deceased alive on 4/29 , 1962 , and that death occurred at 8 A. M., from the causes and on the date stated above. | |
| 22a. SIGNATURE
Wm. Newcomer | | M.D.
Wm. Newcomer, M.D., Superintendent Mt. Wilson, Maryland | | ATTENDING PHYS.
<input type="checkbox"/> | | MED. DIRECTOR
<input type="checkbox"/> | | STAFF PHYS.
<input type="checkbox"/> | | 22b. DATE SIGNED
4/29/62 | | 22c. PHYSICIAN'S NAME (Type)
Wm. Newcomer | | 22d. ADDRESS
Wm. Newcomer, M.D., Superintendent Mt. Wilson, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
May 2, 1962 | | 23c. NAME OF CEMETERY OR CREMATORY
Knoxville Cemetery | | 23d. LOCATION (City, town or county)
Knoxville Ind. | | 23e. REC'D BY REGISTRAR
May 2 '62 | | 23f. REGISTRAR'S SIGNATURE
Arthur S. Kane | | 24. FUNERAL DIRECTOR'S SIGNATURE
Leila Funch Home | | ADDRESS
Brunswick Md | | | |

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Inventory of property
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of the

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|----------------------------------|--|--|--|--|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore (Arbutus)
c. LENGTH OF STAY IN 1b
Baltimore (Arbutus)
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1300 North Avenue | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Md. b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Arbutus)
d. STREET ADDRESS 1300 North Avenue
a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print) Flora C. Warren | | | | | | 4. DATE OF DEATH
Month April Day 21 Year 1962 | | | | | |
| 5. SEX
female | | 6. COLOR OR RACE
white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Sept. 12, 1890 | | 9. AGE (In years last birthday) 71 yrs. | | IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Maryland | | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | |
| 13. FATHER'S NAME
Herman RM Pohlhaus | | | | | | 14. MOTHER'S MAIDEN NAME
Elizabeth Terveer | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Address Walter T. Warren, Sr., 1300 North Ave. #27 | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
422 DUE TO
Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic C/D Disease
stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a.m. 11-3 p.m. 1961
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11-3 , 19 61 , to 4-21 , 19 62 , that (I) (was) last saw the deceased alive on 12-3 , 19 61 , and that death occurred at 2P M, from the causes and on the date stated above. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
10 min.
3 yrs. | |
| 22a. SIGNATURE John F. Schaefer M.D.
22c. PHYSICIAN'S NAME (Type) John F. Schaefer, M. D. | | | | | | | | | | 22b. DATE SIGNED
4-23-62 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF
4/24/62 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION (City, town or county) (State)
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Howard H. Hubbard, 4107 Wilkens Avenue #29 | | | | | | 25a. REC'D BY REGISTRAR
DATE APR 24 1962 | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Hanna | | | |

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the North Avenue

April 21, 1961

Yvonne C. Watson

Serge. J. A. 2290

Serge. J. A. 2290

Marland

Honorable

Mr. Nathan H. Watson

Mr. Nathan H. Watson

Watson, E. Watson, Sr., 1100 North Ave. 521

Watson, E. Watson, Sr., 1100 North Ave. 521

Clayton Watson

Watson, E. Watson, Sr.

Clayton Watson

40 East 11th St.

40 East 11th St.

London Park Cemetery

London Park Cemetery

Howard H. Spence, 1107 Wilson Avenue 522

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **04347**

| | | | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hereford</u>
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HEREFORD RD - RFD-2</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hereford</u>
d. STREET ADDRESS <u>HEREFORD RD - RFD-2</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<u>ARTHUR P. WATSON</u> | | | | 4. DATE OF DEATH Month Day Year
<u>APR. 7 1962</u> | | | | | | | | | | | |
| 5. SEX
<u>MALE</u> | | 6. COLOR OR RACE
<u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>MARCH 29, 1903</u> | | 9. AGE (In years last birthday) <u>59</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>CUSTODIAN</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>SCHOOL</u> | | | | 11. BIRTHPLACE (State or foreign country)
<u>VIRGINIA</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | |
| 13. FATHER'S NAME
<u>WILLIAM R. WATSON</u> | | | | | | 14. MOTHER'S MAIDEN NAME
<u>LILLIE E. FOGELSON</u> | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>NO</u> | | | | 16. SOCIAL SECURITY NO.
<u>216-14-3855</u> | | | | 17. INFORMANT Address
<u>MARGARET L. WATSON - HEREFORD RD</u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____
DUE TO (c) _____ | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>R. M. France</u> | | | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | DATE SIGNED
<u>4/7/62</u> | | | |
| EXAMINER'S NAME (Type) <u>R. M. FRANCE</u> | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | | | 22b. DATE THEREOF
<u>APRIL-7/62</u> | | | | 22c. NAME OF CEMETERY OR CREMATORY
<u>EVERGREEN MEM. GARDENS</u> | | | | 22d. LOCATION (City, town, or county) (State)
<u>FLINKSBURG - MD.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>W. M. COOK - TOWSON, INC. - TOWSON, MD.</u> | | | | | | ADDRESS | | | | 24a. REC'D BY REGISTRAR
DATE <u>APR 6 '62</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. House</u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04352

04348

| | | | |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Overlea
c. LENGTH OF STAY IN lb 5 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4304 Kenwood Ave. | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea
d. STREET ADDRESS 4304 Kenwood Ave.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) ELIZABETH K. WEIKERT | | 4. DATE OF DEATH April 30, 1962 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 14, 1881 |
| 9. AGE (In years last birthday) 81 yrs. | | IF UNDER 1 YEAR
Months 0 Days 0 | IF UNDER 24 HRS.
Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) Maryland |
| 13. FATHER'S NAME John H. Hartline | | 14. MOTHER'S MAIDEN NAME Mary Deigert | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. | | 16. SOCIAL SECURITY NO. Frederick L. Hartline 4304 Kenwood Ave. | |
| 17. INFORMANT Frederick L. Hartline 4304 Kenwood Ave. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Atherosclerotic Cardio Vascular Disease
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Severe Generalized
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Malnutrition - secondary to bowel discomfort & pain | | | |
| INTERVAL BETWEEN ONSET AND DEATH undeb. | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1960 , 19 April 28 , to April 30, 1962 , that (I) (we) last saw the deceased alive on 1960 , and that death occurred at 8 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE John C. Hyle | | 22b. DATE SIGNED 5-1-62 | |
| 22c. PHYSICIAN'S NAME (Type) JOHN C. Hyle | | 22d. ADDRESS 7527 Belair Rd Balto 36 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF May 2, 1962 | |
| 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | 23d. LOCATION (City, town or county) (State) Colgate, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road. | | 25a. REC'D BY REGISTRAR MAY 3 '62 | |
| ADDRESS | | 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas | |

04348

04348

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TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04353

04349

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
7yr6mth27dys | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Etta Middle A. Last West | | 4. DATE OF DEATH
Month April Day 19 Year 19 62 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 4, 1885 |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 9b. AGE (In years last birthday) 76 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
Frederick Schulte | | 14. MOTHER'S MAIDEN NAME
Mary Hubbard | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
unknown | |
| 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic nephritis
592X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis
INTERVAL BETWEEN ONSET AND DEATH | | | |
| MEDICAL CERTIFICATION
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m.
20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from Sept. 21, 1954 to April 19, 1962 , that I last saw the deceased alive on April 19, 1962 , and that death occurred at 7:00 M, from the causes and on the date stated above.
a. ADDRESS (Street, city or town, state) DATE SIGNED
SPRING GROVE STATE HOSPITAL 4-19-62
ACTUAL SIGNATURE Loretta Y. F. Hsu M.D.
PHYSICIAN'S NAME (Type) LORETTA Y. F. HSU Catonsville 28, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
4-21-1962 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Woodlawn | | 22d. LOCATION (City, town, or county) (State)
Woodlawn, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
H. Howard Strong 3207 W. North Ave. | | 24a. REC'D BY REGISTRAR
DATE APR 23 '62 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04354

04350

| | | | | | |
|--|----------------------------|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Balto Co.</i>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Randallstown</i>
c. LENGTH OF STAY IN lb | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE <i>Md.</i>
b. COUNTY <i>Balto</i>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Overlea.</i>
d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <i>ANNIE WHELELL</i>
First Middle Last | | 4. DATE OF DEATH <i>APR 20 - 1962</i>
Month Day Year | | | |
| 5. SEX <i>F</i> | 6. COLOR OR RACE <i>W.</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>OCT 6 - 1867</i>
Month Day Year | 9. AGE (In years last birthday) <i>94</i> yrs. | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore Md</i> | |
| 13. FATHER'S NAME <i>John Schaefer</i> | | 14. MOTHER'S MAIDEN NAME <i>?</i> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> | | 16. SOCIAL SECURITY NO. <i>NONE</i> | | 17. INFORMANT <i>John Wheeler - 3013 Parktown Rd. 34</i>
Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiac failure</i>
DUE TO
Conditions, if any, which gave rise to immediate cause (b) <i>Coronary artery disease</i>
DUE TO
(a), stating the underlying cause last. (c) <i>Generalized arteriosclerosis</i> | | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>1 day</i>
<i>5 yrs</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. <i>19</i> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>2</i> <i>4/2</i> <i>1962</i> , to <i>4/2</i> <i>1962</i> , that (I) (we) last saw the deceased alive on <i>4/2</i> <i>1962</i> , and that death occurred at <i>8 AM</i> , from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
<i>Milton Schlenker</i>
M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <i>Milton Schlenker M.D.</i> | | 22d. ADDRESS <i>6410 Windsor Mill Rd Balto Md.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE THEREOF <i>Apr 24 - 62</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Cem</i> | |
| | | 23d. LOCATION (City, town or county) <i>Baltimore</i> | | (State) <i>Md.</i> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>Lassahn Funeral Home Belair Rd.</i> | | ADDRESS <i>7401</i> | | 25a. REC'D BY REGISTRAR
DATE <i>APR 23 '62</i> | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>Arthur E. Evans</i> | |

04-30

CONFIDENTIAL

04-30

04-30

04-30

04-30

Baltimore, MD

Baltimore, MD

John J. Edgar

John J. Edgar

Baltimore, MD

Baltimore, MD

Baltimore, MD

John J. Edgar

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04355

CERTIFICATE OF DEATH

04351

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN lb
10 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Annapolis, Md. 02-10-2 | |
| 4. DATE OF DEATH
Month April Day 9 Year 1962 | | a. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Lawrence E. Wilde | | 5. SEX male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH June 30, 1894 9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
painter | | 10b. KIND OF BUSINESS OR INDUSTRY PAINTER 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME William Wilde | | 14. MOTHER'S MAIDEN NAME Hilda Edgar | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give year or dates of service) | | 16. SOCIAL SECURITY NO. unknown 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary embolism
DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, (b) Iliac and femoral vein thrombosis
DUE TO
(c) Colon diverticulitis, purulent | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 19 e.m. p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 22 7:35 to April 9 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 9 1962 , and that death occurred at 7:35 M, from the causes and on the date stated above. | | 22a. SIGNATURE Stella Wachslar M.D. 22b. DATE SIGNED 4-10-62 | |
| 22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. | | 22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF April 12-62 | |
| 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial | | 23d. LOCATION (City, town or county) Glen Burnie Md | |
| 24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor | | 25a. REC'D BY REGISTRAR APR 12 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Hume | |

04331

04331

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11

PAVIER

James H. Pavier
1801 10th St.
San Francisco, Cal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04352

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Upperco-Rural</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Upperco-Rural</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Haletown</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Resh</u> Middle <u>DUNCAN</u> Last <u>Wilhelm</u> | | 4. DATE OF DEATH
Month <u>April</u> Day <u>12</u> Year <u>1962</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Nov. 5, 1905</u> |
| 9. AGE (In years last birthday)
<u>56</u> yrs. | | IF UNDER 1 YEAR
Months _____ Days _____ | IF UNDER 24 HRS.
Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Foreman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Road Construction</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Jacob B. Wilhelm</u> | | 14. MOTHER'S MAIDEN NAME
<u>Angelina M. Hale</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>yes</u> | | 16. SOCIAL SECURITY NO.
<u>217-07-7292</u> | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Coronary Heart Disease</u>
DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<u>Suddenly</u>
<u>(?) about 1 month</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)
<input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
_____ | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
_____ | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from <u>July 31</u> , 19 <u>61</u> , to <u>Apr 12</u> , 19 <u>62</u> that I last saw the deceased alive on <u>July 31</u> , 19 <u>61</u> , and that death occurred at <u>3 A.</u> M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<u>Joseph E. Bush</u> M.D. | | ADDRESS (Street, city or town, state)
<u>7 Hampstead Rd</u> | |
| PHYSICIAN'S NAME (Type)
<u>Joseph E. Bush M.D.</u> | | DATE SIGNED
<u>4/12/62</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>4-14-1962</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Mount Baptist</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Baltimore Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Tipton Eline</u> | | ADDRESS
<u>Hampstead Md</u> | |
| 24a. REC'D BY REGISTRAR
<u>APR 16 '62</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hume</u> | |

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

IN SENATE
January 10, 1900

REPORT OF THE REGISTRAR
FOR THE YEAR 1899

ALBANY: J. B. LIPPINCOTT & CO., PRINTERS
1900

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JAN 10 1900

THE REGISTRAR

ALBANY, N. Y.

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

304357

04353

| | | | |
|--|----------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. LENGTH OF STAY IN lb
41 Days | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Veterans Administration Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| 3. NAME OF DECEASED
(Type or print)
HENRY T. WILLIAMS | | 4. DATE OF DEATH
Month APRIL Day 9 Year 19 62 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8/25/91 |
| 9. AGE (In years last birthday)
70 yrs. | | 10. IF UNDER 1 YEAR
Months 9 Days 19 HRS. 62 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Seaman | | 10b. KIND OF BUSINESS OR INDUSTRY
Merchant Marine | |
| 11. BIRTHPLACE (County & State, or foreign country)
Elizabeth City, N.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Elijah Williams | | 14. MOTHER'S MAIDEN NAME
Mary E. Brothers | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
091-14-2760 | |
| 17. INFORMATION
Mrs Selma White, 939 Coleridge Rd. 28 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BILATERAL BRONCHOPNEUMONIA
4-20-0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE
DUE TO (c) UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (1) (this hospital) attended the deceased from 2/27/1962 to 4/9/1962 ; that (1) (we) last saw the deceased alive on 4/9/1962 , and that death occurred at 5:00 PM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
 | | 22b. DATE SIGNED
4/10/62 | |
| 22c. PHYSICIAN'S NAME (Type)
SEBASTIAN RUSSO, M. D. | | 22d. ADDRESS
VAH, FT. HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/13/62 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National | | 23d. LOCATION (City, town or county) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Witzke Funeral Directors | | 25a. REC'D BY REGISTRAR
APR 12 '62 | |
| ADDRESS
4101 Edmondson Avenue Baltimore, Maryland | | 25b. REGISTRAR'S SIGNATURE
 | |

85810

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04354

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Md. b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Glyndon | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Glyndon | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
2 Chatsworth Ave. | | d. STREET ADDRESS
2 Chatsworth Ave. | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) Frances H. Wilson | | 4. DATE OF DEATH
Month April Day 4 Year 19 62 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 8, 1889 |
| 9. AGE (In years last birthday) 72 yrs. | | IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housework | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Charles V. Hummel | | 14. MOTHER'S MAIDEN NAME
Emma Meredith | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Mr. Donald Wilson | | Address
Glyndon, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic Hypertensive C-V Disease
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
none | | INTERVAL BETWEEN ONSET AND DEATH
10 min.
6 yrs. | |
| 20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
none | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
none | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. none
p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
none | | 20f. (City or town) (County) (State)
none | |
| 21. I certify that (I) (we) attended the deceased from 1-13-56 , to Apr. 4 , 19 62 , that (I) (we) last saw the deceased alive on 3-24-62 , and that death occurred at 10:30 P.M., from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
D. D. Caples | | 22b. DATE SIGNED
4-6-62 | |
| 22c. PHYSICIAN'S NAME (Type)
D. D. Caples, M. D. | | 22d. ADDRESS
6 Hanover Rd., Reisterstown, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/7/62 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge Cemetery | | 23d. LOCATION (City, town or county) (State)
Pikesville Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
J. F. Eline & Sons | | 25a. REC'D BY REGISTRAR
APR 9 '62 | |
| ADDRESS
Reisterstown, Md. | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Huns | |

M

Belmont

Clyden

2 Chapin Ave.

French

Female White

Honolulu

Charles V. Jones

No

Personnel Division

Home

Mr. Donald Wilson, Clyden, Md.

Maryland

April 8, 1982

Wilson

2 Chapin Ave.

Clyden

Md.

Belmont

0-135-1

CERTIFICATE OF DEATH

0-135-1

J. E. Elms & Sons, Beltsville, Md.

Wife

John Elms, Beltsville

Beltsville, Md.

Beltsville, Md., Beltsville, Md.

Beltsville, Md., Beltsville, Md.

0-135-1

0-135-1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **04355**

04359

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Villa Nova | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore City | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
4016 Villa Nova Ave. | | d. STREET ADDRESS
3210 Chestnut Ave. | |
| 3. NAME OF DECEASED (Type or print) Clara C. Wooden First Middle Last | | 4. DATE OF DEATH April 26, 19 62 Month Day Year | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 31, 1880 |
| 9. AGE (In years last birthday) 81 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House wife | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
Va, |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
John Jefferson | |
| 14. MOTHER'S MAIDEN NAME
Dora Showalter | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | |
| 16. SOCIAL SECURITY NO.
216-05-5486 | | INFORMANT Address
Harry O. Wooden 3210 Chestnut Ave. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Diabetes mellitus
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c) | | | INTERVAL BETWEEN ONSET AND DEATH
years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from April 17 1962 to April 26, 1962 , that I last saw the deceased alive on April 25 , 19 62 , and that death occurred at 1 p. M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Reuben Hoffman | | ADDRESS (Street, city or town, state) 846 W. 36th St. DATE SIGNED 4-27-62 | |
| PHYSICIAN'S NAME (Type) REUBEN HOFFMAN, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
4-31-1962 | 22c. NAME OF CEMETERY OR CREMATORY
St. Marys. (Hampden) | 22d. LOCATION (City, town, or county) (State)
Baltimore Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Frank H. Seitz | | 24a. REC'D BY REGISTRAR
APR 30 '62 DATE | |
| 24b. REGISTRAR'S SIGNATURE
Arthur L. House | | | |

TO HOSPITAL OR A PROVIDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

04359

(M)

Self-Portrait

111 Ave.

3 Jan.

Washington City

1015 11th Ave.

Clara E. Woodson

3210 Chesapeake Ave.

April 22

White House

August 11, 1880

Housewife

va.

John Peterson

John Peterson

216-00-JAGGER, E. Woodson 3210 Chesapeake Ave.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04350

04356

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON | | | |
| c. LENGTH OF STAY IN b. 10 YEARS | | | | d. STREET ADDRESS 108 LINDEN TERRACE | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 108 LINDEN TERRACE | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) ROBERT D. WORKMAN | | | | 4. DATE OF DEATH APRIL 29 1962 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH DEC 19, 1880 | |
| 9. AGE (In years last birthday) 81 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EXECUTIVE | | 11. BIRTHPLACE (County & State, or foreign country) DANVILLE, OHIO | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME THEODORE WORKMAN | | | | 14. MOTHER'S MAIDEN NAME ALICE WHEATON | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No | | | | 16. SOCIAL SECURITY NO. 274-05-6454 | | | |
| 17. INFORMANT MRS CRYSTAL GILLESPIE | | | | Address 108 LINDEN TERRACE | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma (undifferentiated) of lung with metastases to cervical lymph nodes and through neck structures generally
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) 163X
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Arteriosclerotic heart disease with cardiomegaly and aortic atherosclerosis | | | | INTERVAL BETWEEN ONSET AND DEATH 2 years | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED
While et work <input type="checkbox"/> Not While et work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from January 1, 1958 to April 29, 1962 that (I) (we) last saw the deceased alive on April 26, 1962 and that death occurred at 5 AM from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Richard N. Tillman M.D. | | | | 22b. DATE SIGNED April 29, 1962 | | | |
| 22c. PHYSICIAN'S NAME (Type) RICHARD N. TILLMAN, MD | | | | 22d. ADDRESS 3035 St. Paul St Baltimore, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF MAY 2, 1962 | | 23c. NAME OF CEMETERY OR CREMATORY NORTH CANTON CEMETERY | | 23d. LOCATION (City, town or county) (State) CANTON, OHIO | |
| 24. FUNERAL DIRECTOR'S SIGNATURE HENRY W. JENKINS & SONS ADDRESS 4905 YORK RD BALT 12, MD | | | | 25a. REC'D BY REGISTRAR DATE MAY 2 '62 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas | |

VS A15 (4)
15M 9/60

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---------------------------|--|--|--|---|--------------------------------------|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 04361 | | | | | | 04357 | | | | | |
| 1. PLACE OF DEATH | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) | | | | | |
| a. COUNTY <i>Baltimore</i> | | | MARYLAND | | | a. STATE <i>Md</i> | | | b. COUNTY <i>Haward</i> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westmeir</i> | | | c. LENGTH OF STAY IN lb <i>3 mos</i> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ellicott City</i> | | | 13 X 2 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>1211 Baker Avenue</i> | | | | | | d. STREET ADDRESS <i>Folly Quarter Farm</i> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) <i>Catherine</i> | | | | | | First <i>Rebecca</i> Middle <i>Worley</i> Last <i>Worley</i> | | | 4. DATE OF DEATH <i>April 7 1962</i> | | |
| 5. SEX <i>F</i> | | 6. COLOR OR RACE <i>W</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>11-29-75</i> | | 9. AGE (In years last birthday) <i>86</i> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | | 11. BIRTHPLACE (County & State, or foreign country) <i>Haward Co. Md.</i> | | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | |
| 13. FATHER'S NAME <i>George A. Dumhart</i> | | | | | | 14. MOTHER'S MAIDEN NAME <i>Mary Ann Harding</i> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | | | 16. SOCIAL SECURITY NO. <i>no</i> | | 17. INFORMANT <i>Thamara W. Worley</i> Address <i>2901 Sheridan St Hyattsville Md</i> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>A.S.C.U.D.</i> | | | | | | | | | | | |
| 422 | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c) | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Jan 9 1962</i> to <i>Apr 7 1962</i> that (I) (we) last saw the deceased alive on <i>Apr 7 1962</i> and that death occurred at <i>8:15</i> M, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <i>James G. Howell</i> | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22b. DATE SIGNED <i>4-7-62</i> | | |
| 22c. PHYSICIAN'S NAME (Type) <i>JAMES G. HOWELL</i> | | | | | | 22d. ADDRESS <i>Catonville</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | | 23b. DATE THEREOF <i>4/10/62</i> | | | 23c. NAME OF CEMETERY OR CREMATORY <i>Emmanuel Cem.</i> | | | 23d. LOCATION (City, town or county) (State) <i>Seagoville Md</i> | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>De Witt Candelton</i> | | | | | | ADDRESS <i>Reumel, Md</i> | | | 25a. REC'D BY REGISTRAR <i>APR 11 '62</i> | | |
| | | | | | | | | | 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i> | | |

04357

CERTIFICATE OF DEATH

04357

[Faint, mostly illegible handwritten text, likely a death certificate form. The text is mirrored across the page, suggesting bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04352

CERTIFICATE OF DEATH

04358

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Rural- Woodlawn, 7</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Rural- Woodlawn, 7</u> | |
| c. LENGTH OF STAY in lb
<u>30 yrs.</u> | | d. STREET ADDRESS
<u>1920 Englewood Ave.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>1920 Englewood Ave.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>Mr. Earl</u> <u>O</u> <u>Zentz</u> | | 4. DATE OF DEATH
Month <u>April</u> Day <u>16</u> Year <u>62</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Nov. 22, 1884</u> |
| 9. AGE (In years last birthday) <u>77</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired Foreman</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>William F. Zentz</u> | | 14. MOTHER'S MAIDEN NAME
<u>Katura Virginia Griffe</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give year or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>216-05-9514</u> | |
| 17. INFORMANT
<u>Mrs. Bertha B. Zentz, Baltimore 7, Maryland</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO
(b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
<input type="checkbox"/> | |
| 20a. TIME OF INJURY
Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>4-14-1960 to 4-16-1962</u> | |
| 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>4-10-1962</u> | | 20d. (City or town) (County) (State)
<u>5:30 PM</u> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4-14-1960</u> to <u>4-16-1962</u> that (I) (we) last saw the deceased alive on <u>4-10-1962</u> and that death occurred at <u>5:30 PM</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Samuel Blumenfeld</u> M.D. | | 22b. DATE SIGNED
<u>4-17-62</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Dr. Samuel Blumenfeld</u> | | 22d. ADDRESS
<u>2104 Gwynn Oak Ave., Balto. 7, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>4-19-62</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Krieders Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>Carroll County, Maryland</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Loring Byers</u> | | 25a. REC'D BY REGISTRAR
<u>APR 19 '62</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hanna</u> | | | |

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